Section 1915(b) Waiver
Proposal for California Advancing and Innovating Medi-Cal (CalAIM)

Updated December 16, 2021
with technical corrections incorporated January 2022

Amendment Submitted November 4, 2022

Submitted to the Centers for Medicare & Medicaid Services on June 30, 2021 and amended on November 4, 2022, for Waiver Period of January 1, 2022, to December 31, 2026

MMA Amendment Version of 1915(b) Waiver Preprint (July 18, 2005)

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ATTACHMENTS

COMMONLY USED ACRONYMS

A&I	Audits & Investigations
AAAHC	Accreditation Association for Ambulatory Health Care
AAS	Alternative Access Standard
ABGAR	Annual Beneficiary Grievance and Appeals Reports
ACA	Affordable Care Act
ACB	Approved Claims per Beneficiary
AH	Acute Hospital
AI/AN	American Indian and Alaska Native
ANC	Annual Network Certification
APL	All Plan Letter
ARRA	American Recovery and Reinvestment Act of 2009
ASAM	American Society of Addiction Medicine
BDE	Beneficiary Dental Exception
BH-SAC	Behavioral Health Stakeholder Advisory Committee
BOS	Board of Supervisors
BY	Base Year
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CalAIM	California Advancing & Innovating in Medi-Cal
CalEQRO	California External Quality Review Organization
CBAS	Community Based Adult Services
CBHDA	County Behavioral Health Directors Association of California
CBHPC	California Behavioral Health Planning Council
CAC	Compliance Advisory Committee
CAP	Cost Allocation Plan *or* Corrective Action Plan
CCAC	Cultural Competence Advisory Committee
CCC	Children with Chronic Conditions
CCI	Coordinated Care Initiative

COMMONLY USED ACRONYMS
(continued)

CCP	Cultural Competence Plan
CCPR	Cultural Competence Plan Requirements
CCR	California Code of Regulations
CCS	California Children's Services
CDPH	California Department of Public Health
CDSS	California Department of Social Services
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CHW	California Health and Wellness
CMC	Cal MediConnect
CMHPC	California Mental Health Planning Council
CMS	Centers for Medicare & Medicaid Services
COBRA	Consolidated Omnibus Budget Reconciliation Act
COC	Continuity of Care
COHS	County-Organized Health System
CQS	Comprehensive Quality Strategy
CRM	Customer Relationship Management
CSHCN	Children with Special Health Care Needs
CSR	Customer Services Representative
CY	Calendar Year
Dental MC	Dental Managed Care
DHCS	California Department of Health Care Services
DMC	Drug Medi-Cal
DMC-ODS	Drug Medi-Cal Organized Delivery System
DOP	Date of Payment
DOS	Date of Service
DRG	Diagnostic Related Group

COMMONLY USED ACRONYMS
(continued)

DSH	Disproportionate Share Hospital
D-SNP	Dual Eligible Special Needs Plan
DTI	Dental Transformation Initiative
ECM	Enhanced Care Management
ED	Emergency Department
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
ER	Emergency Room
FAQ	Frequently Asked Questions
FCC	Family Centered Care
FFP	Federal Financial Participation
FFS	Fee-For-Service
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FY	Fiscal Year
FFY	Federal Fiscal Year
GMC	Geographic Managed Care
GME	Graduate Medical Education
HCB	High-Cost Beneficiary
HCBS	Home and Community Based Services
HCO	Health Care Options
HEDIS	Healthcare Effectiveness Data and Information Set
HHAMB	Home Health Agency Market Basket
HIPAA	Health Insurance Portability and Accountability Act of 1996
ICF/MR	Intermediate Care Facilities for the Mentally Retarded
IHSS	In Home Supportive Services

COMMONLY USED ACRONYMS
(continued)

IHP	Indian Health Program
IHP-ODS	Indian Health Program Organized Delivery System
IMD	Institutions for Mental Disease
IMR	Independent Medical Review
IP	Inpatient
LEP	Limited English Proficient
LOC	Level of Care
LOS	Length of Stay
LTSS	Long-Term Services and Supports
MAA	Medi-Cal (or Medicaid) Administrative Activities
MCAS	Managed Care Accountability Set
MCMC	Medi-Cal Managed Care
MCO	Managed Care Organization
MCP	Managed Care Plan
MEG	Medicaid Eligibility Group
MHP	Mental Health Plan (referred to as “County MHP”)
MIPAA	Medicare Improvements for Patients and Providers Act
MIS/DSS	Management Information System/Decision Support System
MLR	Medical Loss Ratio
MLTSS	Managed Long-Term Services and Supports
MMIS	Medicaid Management Information System
MPL	Minimum Performance Level
MHSIP	Mental Health Statistics Improvement Program
MSSP	Multipurpose Senior Services Program
NAR	Notice of Appeal Resolution
NCQA	National Committee for Quality Assurance
NF	Nursing Facilities

COMMONLY USED ACRONYMS
(continued)

NOA	Notice of Action
NOABD	Notices of Adverse Benefit Determinations
NOM	National Outcome Measures
OACT	Office of the Actuary
OBRA	Omnibus Budget Reconciliation Act
OMB	U.S. Office of Management and Budget
PACE	Program of All-Inclusive Care for the Elderly
PAD	Physician Administered Drug
PAHP	Prepaid Ambulatory Health Plan
PCCM	Primary Care Case Management
PCP	Primary Care Physician
PDSA	Plan-Do-Study-Act
PHE	Public Health Emergency
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Plan
PMPM	Per Member Per Month
POS	Performance Outcomes System
PPS	Prospective Payment System
PRIHD	California DHCS Primary, Rural, and Indian Health Division
PSP	Population-Specific Health Plan
QA-UR	Quality Assurance and Utilization Review
QI	Quality Improvement
QIP	Quality Improvement Project
RFP	Request for Proposal
RHC	Rural Health Center
SAC	Stakeholder Advisory Committee
SAMHSA	Substance Abuse and Mental Health Services Administration

COMMONLY USED ACRONYMS
(continued)

SED	Serious Emotional Disturbance (for children)
SFH	State Fair Hearing
SFY	State Fiscal Year
SHP	Specialty Health Plan
SMD	State Medicaid Director
SMI	Serious Mental Illness (for adults)
SMHS	Specialty Mental Health Services
SPA	State Plan Amendment
SPD	Seniors with Persons with Disabilities
STC	Special Terms and Conditions
SUD	Substance Use Disorder
SURS	Surveillance and Utilization Review System
TAR	Treatment Authorization Request
TBS	Therapeutic Behavioral Services
TDD	Telecommunication Device for the Deaf
TPL	Third Party Liability
TTY	TeleTYpe
UCC	Uncompensated Care
UCLA	University of California Los Angeles
UMP	Utilization Review Management Program
UPL	Upper Payment Limit
URC	Utilization Review Accreditation Commission
WPC	Whole Person Care
WIC	California Welfare and Institutions Code
YSS	Youth Services Survey
YSS-F	Youth Services Survey for Families

Proposal for a Section 1915(b) Waiver
MCO, PIHP, PAHP, and/or PCCM Program

Facesheet

Please fill in and submit this Facesheet with each waiver proposal, renewal, or amendment request.

The **State** of ***California*** requests a waiver/amendment under the authority of section 1915(b) of the Act. The Medicaid agency will directly operate the waiver.

The **name of the waiver program** is ***California Advancing & Innovating Medi-Cal (CalAIM)***. (Please list each program name if the waiver authorizes more than one program.).

Type of request. This is an:
___ initial request for new waiver. All sections are filled.

_**X** __ amendment request for existing waiver, which modifies the following Section(s)/Part(s): Section A, Parts I, III, & IV; Section D

__ Replacement pages are attached for specific Section/Part being amended (note: the State may, at its discretion, submit two versions of the replacement pages: one with changes to the old language highlighted (to assist CMS review), and one version with changes made, i.e. not highlighted, to actually go into the permanent copy of the waiver). Document is replaced in full, with changes highlighted

_ renewal request

__ This is the first time the State is using this waiver format to renew an existing waiver. The full preprint (i.e. Sections A through D) is filled out.

__The State has used this waiver format for its previous waiver period. Sections C and D are filled out.

Section A is _ replaced in full

___ carried over from previous waiver period. The State:

___ assures there are no changes in the Program Description from the previous waiver period.

___ assures the same Program Description from the previous waiver period will be used, with the exception of changes noted in attached replacement pages.

Section B is _ replaced in full

___ carried over from previous waiver period. The State:

___ assures there are no changes in the Monitoring Plan from the previous waiver period.

___ assures the same Monitoring Plan from the previous waiver period will be used, with exceptions noted in attached replacement pages

Effective Dates: This waiver/renewal/amendment is requested for a period of **5** years; effective ***January 1, 2022*** and ending ***December 31, 2026***. (For beginning date for an initial or renewal request, please choose first day of a calendar quarter, if possible, or if not, the first day of a month. For an amendment, please identify the implementation date as the beginning date, and end of the waiver period as the end date)

State Contact: The State contact person for this waiver is ***Saralyn Ang-Olson*** and can be reached by telephone at ***(916) 345-8380***, or fax at ***Not Applicable***, or e-mail at ***Saralyn.Ang-Olson@dhcs.ca.gov***. (Please list for each program)

Section A: Program Description

Part I: Program Overview

Tribal consultation

For initial and renewal waiver requests, please describe the efforts the State has made to ensure Federally recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal.

DHCS Response

The State regularly seeks advice from designees of Indian Health Programs and Urban Indian Organizations on matters having a direct effect on Indians, Indian Health Programs (IHPs), or Urban Indian Organizations as required by the American Recovery and Reinvestment Act of 2009 (ARRA). On April 7, 2021, California's Department of Health Care Services (DHCS) provided a memorandum to California Tribal Chairpersons, Indian Health Programs, and Urban Indian Organizations to inform them of this waiver amendment proposal (see Tribal public notice). The State requested that comments be provided within 30 days of the date of the memo, or May 7, 2021.

On April 7, 2021, the State shared the Tribal public notice and information for the Tribal and designees of IHPs advisory meeting to be held on April 30, 2021, via email to the IHPs' listservs. The public notice and information were also posted on the DHCS IHP homepage and in the Notices of Proposed Changes to Medi-Cal Program webpage.

On April 30, 2021, from 2:00 to 3:30 pm Pacific Time, State Medicaid Director Jacey Cooper, along with the DHCS Primary, Rural, and Indian Health Division (PRIHD), hosted the Tribal advisory meeting with approximately 43 attendees. The meeting was held electronically via Zoom to promote social distancing and mitigate the spread of COVID-19. The State made online video streaming and telephonic conference capabilities available to ensure statewide accessibility, as well as closed captioning. During the webinar, Director Cooper provided an overview of the CalAIM waivers, highlighted the potential impact on Tribes of the changes to the Medi-Cal program proposed in the CalAIM waivers, and engaged in a discussion with participants to consider questions and comments.

During the meeting, participants raised concerns about the conclusion of the Tribal Uncompensated Care (UCC) program under the CalAIM Section 1115 demonstration application and impacts to Tribal health programs that do not elect to become Tribal Federally Qualified Health Centers (FQHCs). Additionally, commenters were concerned that Tribal FQHC policies were not yet published. Participants also noted support for the proposed Indian Health Program Organized Delivery System (IHP-ODS), including access to traditional healers and natural helpers in the Drug Medi-Cal-Organized Delivery System (DMC-ODS) program as a way to provide culturally appropriate substance use disorder (SUD) services and supports. The State thanked the Tribes for the operational questions and support and responded that additional details on the Tribal FQHCs' implementation would be available later in May 2021. DHCS published additional Tribal FQHC guidance on May 14, 2021, including details for providers on billing services rendered by Tribal FQHCs

and billing codes, and reviewed the new policy with IHP providers and Tribal organizations on June 11, 2021. As described above, in response to comments, DHCS is seeking authority under the CalAIM Section 1115 demonstration to reinstate the Tribal UCC payments for chiropractic services, which are not accessible for Tribal health programs that do not elect to enroll as a Tribal FQHC.

The PowerPoint presentation used during the Tribal public hearing was posted on the DHCS IHP's Meetings, Webinars, and Presentations webpage and is accessible here.

In addition to the April 30 webinar, DHCS also discussed the CalAIM Section 1115 demonstration application during the regularly scheduled Tribal Quarterly Meetings (March 5, 2021, & May 28, 2021). During the May 28 webinar, DHCS received three comments regarding payment rates for Peer Support Specialists, natural helpers, and traditional healers, as well as a request to continue the Tribal UCC program and a request for responses to public comments submitted during the CalAIM Waiver public comment period on the waiver proposals. DHCS thanked the Tribes for their questions and noted all public comments will be posted on the DHCS CalAIM 1115 Demonstration & 1915(b) Waiver webpage, with responses addressed in the CalAIM Section 1115 demonstration application.

DHCS Update for November 2022 Amendment

For the coordinated CalAIM Section 1915(b) and Section 1115 amendments submitted to CMS in November 2022, the State shared the Tribal public notice on August 12, 2022 via email to the IHPs' listservs and held a webinar for Tribal and designees of IHPs advisory meeting on August 31, 2022. The public notice and information were also posted on the DHCS IHP homepage and in the Notices of Proposed Changes to Medi-Cal Program webpage.

Program History

For renewal waivers, please provide a brief history of the program(s) authorized under the waiver. Include implementation date and major milestones (phase-in timeframe; new populations added; major new features of existing program; new programs added).

DHCS Response

Medi-Cal—California's Medicaid and Children's Health Insurance Program (CHIP)—provides comprehensive health care coverage at no or low cost for 13.4 million low-income individuals, or one in three Californians. More than 11 million individuals access their coverage through Medi-Cal's managed care delivery system programs, which consist of:

- *Medi-Cal Managed Care (MCMC)*
- *Dental Managed Care (Dental MC)*
- *The Specialty Mental Health Services (SMHS) Program; and*
- *The Drug Medi-Cal Organized Delivery System (DMC-ODS).*

Section 1915(b) waivers relevant to specialty mental health services have been in effect in California since 1995. The Medi-Cal Specialty Mental Health Services (SMHS) Consolidation Section 1915(b) waiver expires December 31, 2021.

California is requesting a tenth renewal of the 1915(b) waiver along with amendments to consolidate Medi-Cal managed care delivery system programs currently authorized under California's Medi-Cal 2020 Section 1115 demonstration— MCMC, Dental MC, and DMC-ODS—with SMHS under the Section 1915(b) waiver. Alignment of all managed care authorities will enable the State to simplify California's Medi-Cal managed care delivery system and advance the goal of improving health outcomes and reducing health disparities for Medi-Cal beneficiaries. For example, leveraging one primary federal managed care authority will support standardizing federal requirements to the extent possible and reducing administrative complexity. This simplification in turn supports efforts to innovate and drive improvements in quality and health equity. It also provides an aligned platform for seeking approval for and implementing other improvements over time. This five-year Section 1915(b) waiver renewal and amendment will rename California's SMHS Consolidation waiver as the CalAIM Section 1915(b) waiver.

The context and history of these programs, major milestones, and requests under the 1915(b) waiver renewal are described briefly below.

DHCS Update for November 2022 Amendment

In November 2022, California submitted an amendment to its CalAIM Section 1915(b) waiver to secure authority to implement county-based model changes in the MCMC program. As part of the amendment, DHCS also added or updated language on select policies or programs to reflect the State's current implementation of managed care across delivery systems, including to reflect updated operational details and cost effectiveness assumptions and projections.

Additional context for these changes is described in the sections below.

Medi-Cal Managed Care (MCMC)

MCMC is the foundational delivery system that provides coverage for physical health and nonspecialty mental health services for approximately 82 percent of the Medi-Cal population through Medi-Cal managed care plans (MCPs). MCMC operates in all 58 counties in the State through six MCMC models that vary by county or region:

- *County-Organized Health System (COHS): Beneficiaries are served by a single plan that is created and administered by a county's board of supervisors, or other local health authority.*
- *Two-Plan: Beneficiaries choose between a single publicly run entity known as a local initiative plan and a single commercial plan.*
- *Geographic Managed Care (GMC): Beneficiaries choose from multiple commercial plans.*

- *Regional: Beneficiaries choose between two or more commercial plans operating in 18 contiguous counties as one service area.*
- *Imperial: Beneficiaries in Imperial County choose between two commercial plans.*
- *San Benito: Beneficiaries in San Benito County choose between a single commercial plan and Medi-Cal fee-for-service (FFS).*

MCMC boilerplate contracts are available here.

DHCS Update for November 2022 Amendment

Effective January 1, 2024, MCMC will operate in all 58 counties through four plan models that vary by county or region.

- *COHS and Single Plan: Beneficiaries are served by a single plan that is created and administered by a county's board of supervisors or other local health authority (COHS) or are served by a single publicly run entity known as a local initiative plan or other plan operating under county authority (Single Plan).*[1]
- *Two-Plan: Beneficiaries choose between a single publicly run entity known as a local initiative plan and a single commercial plan.*
- *GMC: Beneficiaries choose from multiple commercial plans.*
- *Regional: Beneficiaries choose between two or more commercial plans operating in 18 contiguous counties as one service area.*

Through an amendment to the 1915(b) submitted to CMS in November 2022, DHCS is seeking authority to limit plan choice in rural counties to allow counties to participate, or continue participating, in the COHS and Single Plan models.

***History and Key Milestones.** MCMC has been authorized in California under successive iterations of Section 1115 demonstrations. Under the original Section 1115 demonstration and its subsequent amendments, the MCMC program expanded to additional counties, began covering seniors and persons with disabilities, and grew to include additional benefits.*

Currently, most Medi-Cal children, pregnant women, parents/caretaker relatives, and most other beneficiaries are required to enroll in MCMC to access their services (mandatory enrollment). American Indians and Alaska Natives, dual eligibles in certain counties, foster children and youth in non-COHS counties, all beneficiaries in San Benito County, and several other populations have the option but are not required to enroll in MCMC (voluntary enrollment). Certain populations—such as beneficiaries with other health care coverage in non-COHS counties and beneficiaries in rural zip codes in non-COHS counties—are excluded from MCMC enrollment, meaning they do not have the opportunity to enroll in an MCP and instead access their Medi-Cal services through FFS (excluded).

[1] Effective January 1, 2024, Kaiser Foundation Health Plan will also operate as a full-risk, full-scope Medi-Cal managed care plan in certain geographic regions of the State. Kaiser would be an option for their existing Medi-Cal enrollment in 22 counties as well as in 10 counties where Kaiser has enrollment in other lines of business for continuity of coverage. In COHS and Single Plan counties where Kaiser Foundation Health Plan operates, Medi-Cal members will have choice of more than one managed care plan.

While most Medi-Cal State Plan services are covered under MCMC, depending on the MCMC model, the responsibility to provide certain benefits may fall under the responsibility of another delivery system.[2] Services not covered under MCMC include SMHS, SUD services, dental, and most long-term services and supports, except that long-term care is covered under MCMC in the seven Coordinated Care Initiative (CCI) counties (Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, Santa Clara) and in COHS counties. The lack of an aligned managed care delivery system complicates the delivery of care and impedes care coordination.

Requests. *Through this Section 1915(b) waiver renewal and amendment, California is seeking to shift the following MCMC program-related authorities previously approved in the Section 1115 demonstration (set to expire December 31, 2021) to Section 1915(b).[3] Specifically, the 1915(b) waiver would:*

- *Continue the authority for mandatory enrollment into MCMC; and*

- *Require individuals dually eligible for Medi-Cal and Medicare in CCI and COHS counties to enroll in MCMC for Medi-Cal benefits in 2022, and it would include institutional long-term care as a managed care benefit in CCI counties, prior to the proposed statewide requirement for dually eligible beneficiaries and long-term care in 2023 (see further below).*

In addition to transitioning previously approved Section 1115 authority, California is seeking in this Section 1915(b) to:

- *Require additional populations to enroll in MCMC (including nearly all dual eligibles in 2023), and*

- *Further standardize benefits offered across California's managed care delivery system.*

These changes promote more coordinated and integrated care statewide and provide beneficiaries who have been in FFS or who have not been required to enroll in an MCP with a network of primary care providers and specialists.

- *<u>Require additional populations to enroll in MCMC (including nearly all dual eligibles in 2023)</u>**.** Starting in 2022, the aid code groups required to enroll in MCMC in all counties are: Trafficking and Crime Victims Assistance Program (except share of cost); Individuals participating in accelerated enrollment; Child Health and Disability*

[2] Pursuant to Executive Order N-01-19, the State is in the process of carving out pharmacy benefits from MCPs as a component of the Medi-Cal Rx initiative.

[3] The Medi-Cal 2020 demonstration includes language outlining that Medi-Cal beneficiaries in selected COHS counties are permitted to enroll in a Program of All-Inclusive Care for the Elderly (PACE) independent of the COHS MCP. CMS has confirmed that express waiver authority is not necessary to continue this allowance under the CalAIM Section 1915(b) waiver for COHS counties where a PACE plan is available.

Prevention infant deeming); and Pregnancy-related Medi-Cal[4] (Pregnant Women only, 138–213 percent of the federal poverty level (FPL) citizen/lawfully present). Some American Indians and Alaska Natives may be eligible for Medi-Cal coverage in these additional aid code groups that will be subject to mandatory MCMC enrollment. As is consistent with current policy, all American Indians and Alaska Natives residing in non-COHS counties will continue to have the ability to opt out of MCMC. Starting in 2022 in non-COHS counties, beneficiaries with other health coverage and beneficiaries in rural zip codes will no longer be excluded and will be subject to mandatory MCMC enrollment.

California is transitioning the CCI—the Medi-Cal managed care program in seven counties that is designed to provide integrated care across delivery systems and rebalance service delivery away from institutional care and into the home and community—to a statewide aligned enrollment structure. The CCI is comprised of: (1) Cal MediConnect (CMC), a Section 1115A demonstration project under the federal Financial Alignment Initiative that combines acute, primary, institutional, and home- and community-based services into a single benefit package for Medicaid eligible individuals who are fully or partially eligible for Medicare; and (2) mandatory Medi-Cal managed care enrollment for dual eligibles for most Medi-Cal benefits and Medi-Cal managed care carve-in for long-term care and some managed long-term services and supports (MLTSS). As noted in the above discussion on shifting MCMC program-related authorities previously approved in the Section 1115 demonstration, DHCS will continue to require individuals dually eligible for Medi-Cal and Medicare in CCI and COHS counties to enroll in MCMC for Medi-Cal benefits in 2022, and include institutional long-term care as a managed care benefit in CCI counties. In 2023, DHCS will require dual eligibles to enroll in MCMC statewide. For dual eligible beneficiaries who opt to enroll in a Medicare Advantage plan, including a dual eligible special needs plan (D-SNP), DHCS will align these beneficiaries' Medi-Cal MCP enrollment with their Medicare Advantage plan enrollment whenever possible to allow for greater integration and coordination of care. DHCS plans to transition to aligned enrollment in select non-COHS counties in 2022, and will expand this approach statewide in future years.[5]

- *<u>Further standardize benefits offered through MCMC</u>. California is seeking to further standardize benefits offered by the MCPs statewide, which will mitigate MCMC enrollee confusion and streamline DHCS administrative rate-setting processes. DHCS intends to carve out to FFS: pharmacy benefits that are billed by a pharmacy on a pharmacy claim including covered outpatient drugs and physician administered drugs (PADs), as described in the Medi-Cal Rx All Plan Letter (APL 20-020)[6]; the*

[4] Under pending State legislation, pregnant women accessing services FFS prior to January 1, 2022, will remain in FFS through their postpartum period and not be mandatorily enrolled in MCMC.
[5] To comply with the Families First Coronavirus Response Act Section 6008(b) conditions to access enhanced match, Share of Cost (non-long term care) beneficiaries will not be disenrolled from CMC until after the expiration of the public health emergency.
[6] Effective January 1, 2022, pharmacy and related benefits (listed in Attachment III) that are billed by a pharmacy on a pharmacy claim, including covered outpatient drugs and physician administered

Multipurpose Senior Services Program (MSSP, currently carved-in to MCMC in CCI counties) effective 2022; and SMHS from the MCMC benefit package for certain Medi-Cal members enrolled in Solano and Sacramento counties no sooner than July 2022 (in alignment with the transition from a cost-based to a rate-based reimbursement in SMHS). DHCS intends to carve into the MCMC benefit package statewide major organ transplants by 2022 and institutional long-term care services (e.g., skilled nursing facilities, pediatric/adult subacute care, disabled/habilitative/nursing services) by 2023. Regardless of the beneficiary's county of residence or the plan they are enrolled in, they will have the same set of benefits through MCMC.

Consistent with State legislation, DHCS has authority for the implementation of a dental integration pilot in San Mateo County as a component of the Medi-Cal 2020 Section 1115 demonstration, or successor thereto. Under the pilot program, Medi-Cal beneficiaries enrolled in MCMC in San Mateo County will be required to access their dental services through the Health Plan of San Mateo. Accordingly, California is seeking the authority for the new pilot—by carving dental services into the benefit package offered by Health Plan San Mateo—in the consolidated Section 1915(b) waiver. The anticipated implementation date for the pilot under the new Section 1915(b) authority is January 2022.

DHCS Update for November 2022 Amendment

Through an amendment to the 1915(b) waiver submitted to CMS in November 2022, DHCS is seeking authority to limit plan choice in rural counties to allow counties to participate, or continue participating, in the COHS and Single Plan models. DHCS also added or updated language on policies or programs to reflect the State's broader model changes and current implementation of managed care across delivery systems.

As part of these updates, DHCS included language to reflect its plan to enter into direct MCP contracts with Kaiser Foundation Health Plan in 32 counties, where Kaiser Foundation Health Plan currently operates as a commercial plan.[7] Pursuant to recent state legislation,[8] the following beneficiary populations residing in affected counties will be eligible to enroll with Kaiser Foundation Health Plan under these direct contracts:

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drugs, medical supplies and enteral nutritional products, as described in the Medi-Cal Rx All Plan Letter (APL 20-020) will be carved out of Medi-Cal managed care capitated benefits. Pharmacy and related benefits that are billed on medical and institutional claims, including physician administered drugs, other outpatient drugs, legend, non-legend and specialty drugs, medical supplies and enteral nutritional products, that are not carved-out to Medi-Cal Rx as discussed above, and further described in Medi-Cal Rx All Plan Letter (APL 20-020), will remain carved in to Medi-Cal managed care capitated benefits.

[7] DHCS is entering into direct MCP contracts with the Kaiser Foundation Health Plan in the following 32 counties: Alameda, Amador, Contra Costa, El Dorado, Fresno, Imperial, Kern, Kings, Los Angeles, Madera, Marin, Mariposa, Napa, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma, Stanislaus, Sutter, Tulare, Ventura, Yolo, and Yuba.

[8] See Assembly Bill No. 2724 (Chapter 73, Statutes of 2022); Cal. Welfare and Institutions Code section 14197.11.

- *A beneficiary previously enrolled with Kaiser Foundation Health Plan as their MCP at any point during calendar year 2023;*
- *A beneficiary who is an existing Kaiser Foundation Health Plan member upon transition into MCMC;*
- *A beneficiary who was a member of Kaiser Foundation Health Plan at any time during the 12 months preceding the effective date of their Medi-Cal eligibility;*
- *A beneficiary with "family linkage" to Kaiser Foundation Health Plan whereas one or more of the following individuals are a current member of Kaiser Foundation Health Plan upon the effective date of that beneficiary's Medi-Cal eligibility: a beneficiary's spouse or domestic partner; a beneficiary's dependent child, foster child or stepchild under 26 years of age; a beneficiary's dependent who is disabled and over 21 years of age; a parent or stepparent of a beneficiary under 26 years of age; or a grandparent, guardian, foster parent, or other relative with appropriate documentation of a familial relationship of a beneficiary under 26 years of age;*
- *A beneficiary previously enrolled in a primary MCP other than Kaiser Foundation Health Plan, but was assigned to Kaiser Foundation Health Plan under a subcontract with that primary MCP at any time during calendar year 2023;*
- *A beneficiary dually eligible for Medi-Cal and Medicare in select counties in which Kaiser Foundation Health Plan operates as a MCP;*
- *A beneficiary who is in foster care or is a former foster care youth that elects to enroll in MCMC; and*
- *A beneficiary not listed above who is assigned to Kaiser Foundation Health Plan according to DHCS' default enrollment process for beneficiaries that fail to select a MCP during the plan choice period, subject to an annual cap based on projected capacity.*

Dental Managed Care (Dental MC)

Dental services are currently provided through Dental MC plans in two California counties—Sacramento and Los Angeles. In the remaining counties, dental services are available through FFS. The Dental MC boilerplate contract is included for reference in "Attachment I: Dental MC Boilerplate Contract."

History/Key Milestones. *Under the authority of the Section 1115 demonstration, the Dental MC – GMC Sacramento program was implemented in 1995 to explore the effectiveness of managed care as a delivery system for providing eligible Medi-Cal members with dental services. GMC services are provided by dental plans contracted and licensed by the state pursuant to the Knox-Keene Health Care Services Plan Act of 1975 (Knox-Keene Act). Through a Section 1915(a) waiver no longer in use by CMS, the Dental MC – PHP Los Angeles program has operated since 1995.*

Request. *Like MCMC, Dental MC in Sacramento County is currently authorized under California's Medi-Cal 2020 Section 1115 demonstration through December 31, 2021. California is seeking to shift authority for Dental MC in Sacramento to Section 1915(b). DHCS affirmed with CMS that Dental MC in Los Angeles County may remain under Section 1915(a) and does not require additional authority under the Section 1915(b) waiver. DHCS*

continues to evaluate the effectiveness of Dental MC and may seek modifications to the delivery system program in the future based on that evaluation and/or State legislative or budget changes.

Specialty Mental Health Services (SMHS)

SMHS are currently provided by 56 county mental health plans (County MHPs) covering all 58 counties throughout the State, including two joint-county arrangements in Sutter/Yuba and Placer/Sierra. The County MHPs are required to provide or arrange for the provision of SMHS to beneficiaries in their counties who meet criteria for services, consistent with beneficiaries' mental health treatment needs and goals. The SMHS boilerplate contract is available here.

History/Key Milestones. *In 1995, under the authority of a Section 1915(b) waiver (the Medi-Cal Psychiatric Inpatient Hospital Service Consolidation waiver), California made county mental health departments responsible both for mental health services provided under the Short-Doyle Medi-Cal program (in which community mental health services were delivered by counties through directly operated and contracted providers) and for those provided under the FFS Medi-Cal program, such as psychiatric inpatient hospital services. In 1997, under the authority of a renewed, modified, and renamed Section 1915(b) waiver (the Medi-Cal SMHS Consolidation waiver) California consolidated responsibility for inpatient hospital and outpatient, professional, case management, and other SMHS under the responsibility of a single MHP in each county.*

The SMHS program evolved through numerous renewals to the State's current Section 1915(b) waiver for SMHS and other policy changes. Major milestones in this evolution include the transfer of responsibility for the SMHS waiver program from California's Department of Mental Health to DHCS; various State Plan Amendments (SPAs) to update sections describing SMHS and reimbursement; and other contract, quality improvement, and monitoring programs updates and improvements. In addition, State program responsibilities and revenues were realigned to local governments (primarily counties) in 1991 and 2011. In total, the 2011 realignment provided $6.3 billion to local governments (primarily counties) to fund various criminal justice, mental health, and social services programs in 2011–12, and ongoing funds for these programs annually thereafter.

Request. *The SMHS program is currently authorized under California's SMHS Section 1915(b) waiver through December 31, 2021. Through the renewal of the Section 1915(b) waiver, California is seeking to renew that authority and consolidate other Medi-Cal managed care authorities with SMHS.*

DHCS is also seeking to add new SMHS services at county option. Consistent with State legislation, DHCS will be establishing peer support specialist services. Peer support specialist services are culturally competent services, provided by certified peer support specialists, that promote recovery, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths. Peer support specialists will support California's effort to promote health equity by providing culturally competent services to promote recovery and enhanced access to care across a diverse population, including race/ethnicity, gender identity, sexual orientation, generation, and

geographic regions. DHCS will use the Medi-Cal State Plan to include peer support specialist services. CMS confirmed for DHCS that the waivers of statewideness and comparability for SMHS delivery system extend to the benefits offered under the delivery system and enable peer support services to be made .available at the option of each county under SMHS consistent with State legislation. (Peer support specialist services will also be available in DMC-ODS, discussed further in the next section.)

Additional Details. *In tandem with the consolidated Section 1915(b) waiver, California will also make programmatic changes to the SMHS delivery system that will be implemented through State legislation and regulation; County MHP contract; and policy and operational guidance. These changes are aimed at improving access to appropriate care and standardizing access to the SMHS delivery system statewide. A core improvement is clarifying the current division of responsibilities between Medi-Cal MCPs and County MHPs and updating the criteria for access to SMHS both for adults and for beneficiaries under age 21.*

As defined in State law, Medi Cal MCPs are responsible for providing covered nonspecialty mental health services to adult beneficiaries with mild to moderate distress or mild to moderate impairment of mental, emotional, or behavioral functioning resulting from mental health disorders, as defined by the current Diagnostic and Statistical Manual of Mental Disorders, as well as beneficiaries with potential mental health disorders not yet diagnosed. Consistent with the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) mandate under Social Security Act (the Act) § 1905(r), Medi-Cal MCPs are responsible for providing all medically necessary nonspecialty mental health services for beneficiaries under the age of 21.

County MHPs are responsible for covering specialty mental health services for Medi-Cal beneficiaries who meet specified criteria for services, which differ for adult beneficiaries and for beneficiaries under age 21. SMHS are defined and detailed in the County MHP contract. Consistent with the EPSDT mandate, County MHPs are responsible for providing all medically necessary SMHS for beneficiaries under the age of 21.

DHCS is also making programmatic changes to: improve access to care prior to formal diagnosis; streamline intake, assessment, referral, and documentation processes; move from a cost-based to a rate-based reimbursement approach. Finally, during this next Section 1915(b) waiver period, DHCS will be working towards administrative integration of specialty mental health and SUD services into one behavioral health managed care program. The goals of administrative integration are to improve outcomes for beneficiaries through coordinated treatment across the continuum of care and to reduce administrative and fiscal burdens for counties, providers, and the State.

DHCS Update for November 2022 Amendment

As part of the amendment submitted to CMS in November 2022, DHCS is seeking authority to allow counties, on a voluntary basis, to adopt an integrated contract structure for the SMHS and DMC-ODS delivery systems. This step represents an initial phase ahead of a more robust initiative for behavioral health administrative integration.

- *As background, state law directs DHCS to integrate specialty mental health and SUD services into a single county-based behavioral health delivery system effective January 1, 2027.[9] This is one component of DHCS's broader Behavioral Health Administrative Integration initiative, which aims to improve beneficiary health care outcomes and reduce administrative burdens for beneficiaries, providers, counties, and the State. DHCS will work with CMS in advance to secure all needed federal authorities to implement this integrated contract structure statewide.*

- *Before statewide implementation in 2027, DHCS seeks to gain experience with the integrated contract structure through an initial phase in select counties beginning on or after January 1, 2025. Accordingly, California is seeking the authority for this initial phase for counties that have opted into DMC-ODS (described below).[10] For counties that opt in, the initial phase will involve executing a single prepaid inpatient health plan (PIHP) contract that covers both SMHS and DMC-ODS services, rather than operating two side-by-side PIHP contracts that are subject to virtually identical federal requirements. This structure will support integration of beneficiary-facing communications (e.g., access lines and member handbooks) as well as state oversight functions (e.g., network adequacy and external quality reviews). DHCS anticipates that the integrated PIHP contract in this initial phase will combine all material elements from the SMHS and DMC-ODS boilerplate PIHP contracts, and will ensure that the integrated contract complies with all requirements applicable to each program under state and federal law, including this waiver. Lessons learned from this initial phase will support DHCS's planning for administrative integration on a statewide basis, including collaboration with CMS on any necessary federal approvals, as noted above.*

Drug Medi-Cal Organized Delivery System (DMC-ODS)

California counties have the option to participate in the DMC-ODS program under the Medi-Cal 2020 Section 1115 demonstration to provide Medi-Cal beneficiaries who reside in their county with a range of evidence-based SUD treatment services in addition to those that were available under the Medi-Cal State Plan at the time. As of June 2021, 37 of California's 58 counties have implemented DMC-ODS, covering 96 percent of the total Medi-Cal population across the State. DHCS is actively engaging with prospective new counties to participate in DMC-ODS, with the goal of eventually expanding DMC-ODS services to Medi-Cal beneficiaries statewide.

The DMC-ODS boilerplate contract is available here.

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[9] California Welfare & Institutions Code § 14184.404.

[10] DHCS does not believe that any new authority is required under 1915(b) for the initial phase with respect to counties that have *not* opted into DMC-ODS. These counties will retain the current model of administering SUD services in a fee-for-service delivery system alongside their SMHS prepaid inpatient health plan (PIHP) contract. The SMHS PIHP contract may be amended to further promote clinical and administrative integration, where appropriate, but will remain compliant with all elements under this waiver and applicable law.

History/Key Milestones. *Medi-Cal has long provided coverage of certain SUD treatment benefits through its DMC-ODS program, which is authorized through the Medi-Cal State Plan and administered by counties. In 2015, the State created the DMC-ODS program and secured a Section 1115 demonstration amendment to standardize service delivery across participating counties, and provide a broader continuum of high-quality, evidenced-based SUD treatment services. In connection with the DMC-ODS program, the State was first in the nation to receive expenditure authority for services that were previously not eligible for reimbursement due to the IMD (institutions for mental diseases) exclusion.*

Request. *The DMC-ODS program was originally authorized under California's Medi-Cal 2020 Section 1115 demonstration, and extended through December 31, 2021. Under CalAIM, DHCS is continuing and strengthening the SUD treatment system, building on the existing DMC-ODS program. To minimize unnecessary reliance on a Section 1115 demonstration and to pursue a consistent approach to its delivery system authorities, California is seeking to:*

- *Shift the managed care authority for DMC-ODS to the consolidated Section 1915(b) waiver;*
- *Use the Medi-Cal State Plan to authorize most benefits; and*
- *Secure waivers of statewideness and comparability in the Section 1915(b) waiver to continue to offer these services at county option.*

Consistent with State legislation, DHCS will be establishing peer support specialist services (described above in SMHS). DHCS will use the Medi-Cal State Plan to include peer support specialist services. CMS confirmed for DHCS that the waivers of statewideness and comparability for the DMC-ODS delivery system extend to the benefits offered under the delivery system and enable peer support services to be made available at the option of each county under DMC-ODS. (DHCS is submitting a similar Section 1115 demonstration request for Drug Medi-Cal (DMC).)

Finally, expenditure authority to reimburse Medi-Cal services not otherwise reimbursable due to the IMD exclusion for short-term residential services will remain in the Section 1115 demonstration.

DHCS Update for November 2022 Amendment

Behavioral Health Administrative Integration Initiative: As described above, DHCS is seeking authority to allow certain counties, on a voluntary basis, to enter into an integrated contract structure for the SMHS and DMC-ODS delivery systems.

A. Statutory Authority

1. **Waiver Authority.** The State's waiver program is authorized under section 1915(b) of the Act, which permits the Secretary to waive provisions of section 1902 for certain purposes. Specifically, the State is relying upon authority provided in the following subsection(s) of the section 1915(b) of the Act (if more than one program authorized by this waiver, please list applicable programs below each relevant authority):

   a. **X** **1915(b)(1)** – The State requires enrollees to obtain medical care through a primary care case management (PCCM) system or specialty physician services arrangements. This includes mandatory capitated programs.

   b. ___ **1915(b)(2)** - A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among PCCMs or competing MCOs/PIHPs/PAHPs in order to provide enrollees with more information about the range of health care options open to them.

   c. __ **1915(b)(3)** - The State will share cost savings resulting from the use of more cost-effective medical care with enrollees by providing them with additional services. The savings must be expended for the benefit of the Medicaid beneficiary enrolled in the waiver. Note: this can only be requested in conjunction with section 1915(b)(1) or (b)(4) authority.

   d. **X** **1915(b)(4)** - The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services. The State assures it will comply with 42 CFR 431.55(f).

      The 1915(b)(4) waiver applies to the following programs
      - **X** MCO *(Applies to MCMC)*
      - **X** PIHP *(Applies to SMHS, DMC-ODS)*
      - **X** PAHP *(Applies to Dental MC)*
      - ___ PCCM (Note: please check this item if this waiver is for a PCCM program that limits who is eligible to be a primary care case manager. That is, a program that requires PCCMs to meet certain quality/utilization criteria beyond the minimum requirements required to be a fee-for-service Medicaid contracting provider.)
      - ___ FFS Selective Contracting program (please describe)

2. **Sections Waived.** Relying upon the authority of the above section(s), the State requests a waiver of the following sections of 1902 of the Act (if this waiver authorizes multiple programs, please list program(s) separately under each applicable statute):

   a. **X** **Section 1902(a)(1)** - Statewideness--This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This

waiver program is not available throughout the State. *(Applies to MCMC, Dental MC, SMHS, DMC-ODS)*

b. **X** **Section 1902(a)(10)(B)** - Comparability of Services--This section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver program includes additional benefits such as case management and health education that will not be available to other Medicaid beneficiaries not enrolled in the waiver program. *(Applies to MCMC, SMHS, DMC-ODS)*

c. **X** **Section 1902(a)(23)** - Freedom of Choice--This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, beneficiaries enrolled in this program must receive certain services through an MCO, PIHP, PAHP, or PCCM. *(Applies to MCMC, Dental MC, SMHS, DMC-ODS)*

d. **X** **Section 1902(a)(4)** - To permit the State to mandate beneficiaries into a single PIHP or PAHP, and restrict disenrollment from them. (If state seeks waivers of additional managed care provisions, please list here). *(Applies to MMC in COHS and Single Plan counties, Dental MC, SMHS, DMC-ODS)*

e. **X** **Other Statutes and Relevant Regulations Waived** - Please list any additional section(s) of the Act the State requests to waive, and include an explanation of the request.

DHCS Response

In addition to the above waivers of the Act § 1902, DHCS requests waivers of the following federal regulations for the operation of CalAIM:

Table 1: Waivers of Regulatory Provisions for the Operation of CalAIM

Statutory/Regulatory Section	*Applies to:*
42 CFR § 438.10(g)-(h)	*SMHS, DMC-ODS*
42 CFR § 438.10(i)	*DMC-ODS*
42 CFR § 438.52(a)(1)	*SMHS, DMC-ODS*
42 CFR § 438.56	*SMHS, DMC-ODS*
42 CFR § 438.350	*DMC-ODS*

CMS previously approved waivers of these regulatory provisions in California's SMHS Section 1915(b) waiver for SMHS or Medi-Cal 2020 Section 1115 demonstration for DMC-ODS.

***42 CFR § 438.10(g)-(h):** DHCS requests a waiver of 42 CFR § 438.10(g)-(h), which establishes specific requirements for the types, content, and distribution of information describing the SMHS and DMC-ODS programs. This allows County MHPs to provide informing materials and provider lists that meet the content requirements of § 438.10 to*

beneficiaries when they first access SMHS through the County MHP and on request, and DMC-ODS to provide informing materials and provider lists that meet the content requirements of § 438.10 to beneficiaries when they first access SUD services through the DMC-ODS and on request. The waiver of subsections (g) and (h) would apply to the distribution requirements only, not to any other provisions of the subsections except as directly related to the issue of distribution. CMS previously approved a waiver of this regulatory provision as 42 CFR § 438.10(f)(3) (prior to amendments made through CMS' 2016 Medicaid managed care rule) in California's SMHS Section 1915(b) waiver and Medi-Cal 2020 Section 1115 demonstration. To the extent necessary, the continuation of waivers previously granted are requested of all sections of the federal regulations that mention the obligation to inform all enrollees, to instead allow informing of all beneficiaries on request and/or when a beneficiary first accesses SMHS though a County MHP, or SUD services through DMC-ODS.

42 CFR § 438.10(i): *DHCS requests a waiver of 42 CFR § 438.10(i), which establishes specific requirements for the types, content, and distribution of information describing DMC-ODS. This allows the DMC-ODS plan to provide informing materials and provider lists that meet the content requirements of § 438.10 to beneficiaries when they first access SUD services through the DMC-ODS and on request. The waiver of subsection (i) would apply to the distribution requirements of the subsection only, not to any other provisions of the subsection except as directly related to the issue of distribution. CMS previously approved a waiver of this regulatory provision as 42 CFR § 438.10(f)(3) (prior to amendments made through CMS' 2016 Medicaid managed care rule) in California's Medi-Cal 2020 Section 1115 demonstration. To the extent necessary, the continuation of waivers previously granted are requested of all sections of the federal regulations that mention the obligation to inform all enrollees, to instead allow informing of all beneficiaries on request and/or when a beneficiary first accesses SUD services through DMC-ODS.*

42 CFR § 438.52(a)(1), .56: *DHCS requests a waiver of 42 CFR § 438.52(a)(1), which provides that a State that requires Medicaid beneficiaries to enroll in an MCO, a PIHP, or a PAHP must provide beneficiaries with a choice of at least two MCOs, PIHPs, or PAHPs. DHCS also requests a waiver of 42 CFR § 438.56, which provides the circumstances in which a state must allow a beneficiary to disenroll from an MCO, a PIHP, or a PAHP. The waiver of these two regulatory provisions is necessary to permit DHCS to restrict:*

- *Beneficiaries to receive SMHS from their County MHP, without any option for disenrollment; and*
- *Beneficiaries in counties that have implemented DMC-ODS to receive SUD services to their county's DMC-ODS PIHP, without any option for disenrollment.*

CMS previously approved waivers of these regulatory provisions in California's SMHS Section 1915(b) waiver for SMHS and Medi-Cal 2020 Section 1115 demonstration for DMC-ODS.

42 CFR § 438.350: *DHCS requests a waiver of 42 CFR § 438.350, which requires the performance of an external quality review for the first year of a county's implementation of DMC-ODS. Counties will be required to comply with all external quality review requirements*

after year one of their implementation of the DMC-ODS program. CMS previously approved a waiver of this regulatory provision in California's Medi-Cal 2020 1115 demonstration.

42 CFR § 440.169(d)(2), (4), 42 CFR § 441.18(a)(7): DHCS requests a waiver of 42 CFR § 440.169(d)(2), which requires the development and periodic revision of a care plan with specified components for Targeted Case Management services, insofar as this requirement is inconsistent with the CalAIM goal of streamlining documentation processes described above in Section A, Part 1: Program History. Targeted Case Management is a covered SMHS, and the required components of a care plan set forth in 42 CFR § 440.169(d)(2) create administrative burden for County MHPs and contracted providers that are implementing CalAIM clinical documentation reform policies for SMHS. DHCS also requests a waiver of 42 CFR § 440.169(d)(4) and 42 CFR § 441.18(a)(7) which reference the care plan set forth in 42 CFR § 440.169(d)(2).

Inapplicable Regulatory Provisions
Finally, based on prior DHCS discussions with CMS and through SMHS and DMC-ODS boilerplate contract review and approvals, CMS made the determination a number of provisions of 42 CFR Part 438 are not applicable to SMHS and DMC-ODS either because they are nonrisk PIHPs or these requirements are not consistent with the design and structure of the delivery system. For clarity, DHCS is including these inapplicable provisions here.

Provisions that do not apply to SMHS and DMC-ODS, except as noted:

- *42 CFR § 438.3(b) Standard Contract Requirements – Entities eligible for comprehensive risk contracts*
- *42 CFR § 438.3(c) Standard Contract Requirements – Payment*
- *42 CFR § 438.3(g) Standard Contract Requirements – Provider preventable conditions (SMHS only)*
- *42 CFR § 438.3(o) Standard Contract Requirements – Long term supports and services (LTSS) contract requirements*
- *42 CFR § 438.3(p) Standard Contract Requirements – Special rules for HIOs*
- *42 CFR § 438.3(s) Standard Contract Requirements – Requirements for MCOs, PIHPs, or PAHPs that provide covered outpatient drugs*
- *42 CFR § 438.4 Actuarial Soundness*
- *42 CFR § 438.5 Rate Development Standards*
- *42 CFR § 438.6 Special Contract Provisions Related to Payment*
- *42 CFR § 438.7 Rate Certification Submission*
- *42 CFR § 438.8 Medical Loss Ratio (MLR) Standards*
- *42 CFR § 438.9 Provisions that Apply to Non-emergency Medical Transportation*
- *42 CFR § 438.10(i) Information for all enrollees of MCOs, PIHPs, PAHPs, and PCCM entities: Formulary (SMHS only)*
- *42 CFR § 438.50 State Plan Requirements*
- *42 CFR § 431.51(b)(2) and § 441.202 (No family planning services, including abortion procedures, are provided through the DMC-ODS or SMHS delivery system)*
- *42 CFR § 438.54(c) Voluntary Managed Care Enrollment*
- *42 CFR § 438.70 Stakeholder engagement when LTSS is delivered through a managed care program*

- *42 CFR § 438.71(b)(1)(i) and (iii),(c) and (d) – Client Support System*
- *42 CFR § 438.74 State Oversight of the Minimum MLR Requirement*
- *42 CFR § 438.104 Marketing Activities*
- *42 CFR § 438.110 Member Advisory Committee*
- *42 CFR § 438.114 Emergency and Post-Stabilization Services*
- *42 CFR § 438.116 Solvency Standards*
- *42 CFR § 438.208(c)(1) Identification of Individuals with Special Health Care Needs*
- *42 CFR § 438.700-730 Sanctions*
- *42 CFR § 438.802 Basic Requirements*
- *42 CFR § 438.810 Expenditures for Enrollment Broker Services*
- *42 CFR § 438.816 Expenditures for the Beneficiary Support System for Enrollees Using LTSS*
- *42 CFR § 455.100-104 Disclosure Requirements*
- *Specific provisions related to Religious or Moral Objections to Delivering Services*
- *Specific provisions related to Drug Formularies and Covered Outpatient Drugs, including but not limited to 42 CFR § 438.3(s)*
- *Specific provisions related to LTSS, including but not limited to 42 CFR § 438.3(o) and 438.70*

California's negotiations with the federal government and any changes required by State legislation and/or the State budget could lead to refinements in the authorities sought, or the federal approval for such authorities, as DHCS works with CMS to move the CalAIM initiative forward.

B. Delivery Systems

1. **Delivery Systems**. The State will be using the following systems to deliver services:

   a. _X_ **MCO:** Risk-comprehensive contracts are fully-capitated and require that the contractor be an MCO or HIO. Comprehensive means that the contractor is at risk for inpatient hospital services and any other mandatory State plan service in section 1905(a), or any three or more mandatory services in that section. References in this preprint to MCOs generally apply to these risk-comprehensive entities. *(Applies to MCMC)*

   b. _X_ **PIHP:** Prepaid Inpatient Health Plan means an entity that: (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments or other payment arrangements that do not use State Plan payment rates; (2) provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. Note: this includes MCOs paid on a non-risk basis.

   ___ The PIHP is paid on a risk basis.
   _X_ The PIHP is paid on a non-risk basis. *(Applies to SMHS, DMC-ODS)*

   c. _X_ **PAHP:** Prepaid Ambulatory Health Plan means an entity that: (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State Plan payment rates; (2) does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. This includes capitated PCCMs.

   _X_ The PAHP is paid on a risk basis. *(Applies to Dental MC)*
   ___ The PAHP is paid on a non-risk basis.

   d.___ **PCCM:** A system under which a primary care case manager contracts with the State to furnish case management services. Reimbursement is on a fee-for-service basis. Note: a capitated PCCM is a PAHP.

   e. ___ **Fee-for-service (FFS) selective contracting**: A system under which the State contracts with specified providers who are willing to

meet certain reimbursement, quality, and utilization standards. Reimbursement is:
___ the same as stipulated in the state plan
___ is different than stipulated in the state plan (please describe)

f.___ **Other:** (Please provide a brief narrative description of the model.)

2. <u>Procurement</u>. The State selected the contractor in the following manner. Please complete for each type of managed care entity utilized (e.g. procurement for MCO; procurement for PIHP, etc.):

_X_ **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience) *(Applies to MCMC for the commercial plans operating in the GMC-PHP, Regional, Imperial, San Benito, and Two-Plan counties; Dental MC)*
___ **Open** cooperative procurement process (in which any qualifying contractor may participate)
___ **Sole source procurement**
_X_ **Other** *(Applies to MCMC for the county operated plans in the COHS counties and the local initiative plan in the Two-Plan counties, SMHS, DMC-ODS; Updates for November 2022 1915(b) Waiver Amendment: Also applies to MCMC for the local initiative plan in the Single Plan counties, and to direct contracts with Kaiser Foundation Health Plan in COHS, Single Plan, GMC, Two Plan, and Regional Model counties)* (please describe)

<u>DHCS Response</u>

MCMC: *In COHS counties, beneficiaries are served by a single plan that is created and administered by a county's board of supervisors, or other local health authority. The county Board of Supervisors (BOS) may establish, by ordinance, a commission to negotiate a COHS contract with DHCS. The commission serves as an independent oversight entity for the delivery of Medi-Cal managed care services in that county. COHS contracts may be on a non-bid basis and exempt from Chapter 2 of Part 2 of the Public Contract Code. See California Welfare and Institutions Code (CA WIC) Article 2.8, Chapter 7, Part 3, Division 9. In Two-Plan counties, beneficiaries choose between a single publicly run entity known as a local initiative plan and a single commercial plan. Counties establish a Local Initiative by county ordinance. See CA WIC, Prepaid Plans, Chapter 8, Part 3, Division 9 and California Code of Regulations, Title 22, Section 53800 et. Seq.*

<u>DHCS Update for November 2022 Amendment</u>

***MCMC**: Also applies in Single Plan counties where beneficiaries are served by a single plan that is an expansion of a county-driven Local Initiative or plan otherwise operating under a county authority.*

Also applies to direct contracts with Kaiser Foundation Health Plan in COHS, Single Plan, GMC, Two Plan, and Regional Model counties. Direct contracts with Kaiser Foundation Health Plan are legislatively authorized on a non-bid basis and exempt from Chapter 2 of Part 2 of the Public Contract Code.[11]

***SMHS:** CA WIC § 14712 directs DHCS to implement managed mental health care for Medi-Cal beneficiaries through contract with MHPs. MHPs may include individual counties, counties acting jointly, or nongovernmental entity determined by DHCS to meet MHP standards. A contract may be exclusive and may be awarded on a geographic basis.*

***DMC-ODS:** Any county that elects to opt into DMC-ODS services shall submit an implementation plan to DHCS for approval by DHCS. Upon approval of the implementation plan, the DHCS enters into an intergovernmental agreement with the County to provide or arrange for the provision of DMC-ODS services.*

C. Choice of MCOs, PIHPs, PAHPs, and PCCMs

1. Assurances.

___ The State assures CMS that it complies with section 1932(a)(3) of the Act and 42 CFR 438.52, which require that a State that mandates Medicaid beneficiaries to enroll in an MCO, PIHP, PAHP, or PCCM must give those beneficiaries a choice of at least two entities.

X The State seeks a waiver of section 1902(a)(4) of the Act, which requires States to offer a choice of more than one PIHP or PAHP per 42 CFR 438.52. Please describe how the State will ensure this lack of choice of PIHP or PAHP is not detrimental to beneficiaries' ability to access services. *(Applies to SMHS, DMC-ODS)*

DHCS Response

[11] California Welfare & Institutions Code section 14197.11.

DHCS requests a waiver of the Act §1902(a)(4) for SMHS and DMC-ODS. CMS previously approved waivers of this provision in California's SMHS Section 1915(b) waiver and Medi-Cal 2020 1115 demonstration.

***SMHS**: Pursuant to 42 CFR § 438.68, 438.206, and 438.207, and CA WIC § 14197, DHCS contractually requires County MHPs to maintain and monitor a network of appropriate providers that is sufficient to provide adequate access to all covered services for all beneficiaries, including those with limited English proficiency or physical and mental disabilities. County MHPs are contractually required to meet and require their providers to meet State-established standards for provider ratios, time and distance, and timely access to care and services, taking into account the urgency of need for services. To accomplish this, County MHPs must establish mechanisms to ensure that network providers comply with timely access requirements; monitor network providers regularly to determine compliance with timely access requirements; and take corrective action in response to identified noncompliance.*

Further, County MHPs are required to provide beneficiaries access to out-of-network providers if an in-network provider is not available within the time and distance standards per 42 CFR § 438.206(b)(4); California Information Notice 21-008. Also, pursuant to CA WIC § 14197.04, if DHCS grants the County MHP's request for an alternative access standard for psychiatrists, upon request from the beneficiary, the County MHP must assist the beneficiary in obtaining an appointment with a psychiatrist within the time and distance standards. If the County MHP is unable to arrange such appointment, the beneficiary's MCP must arrange transportation for the enrollee.

The lack of choice between multiple County MHPs in each county is not detrimental to beneficiaries' access to services because California's network adequacy requirements, provided by CA WIC § 14197 and set forth in greater detail in Information Notice 21-023 and the County MHP contract, ensure that all beneficiaries have adequate access to all medically necessary covered services as required by 42 CFR § 438.68, 438.206, and 438.207 and a choice of providers within the County MHP network. DHCS has been working closely with low-performing counties to remedy any identified deficiencies in access to services. By mid-2022, DHCS will establish a consistent and cohesive approach for sanctions and network adequacy to ensure alignment across behavioral health, dental, and medical benefits, including imposing financial sanctions where appropriate as part of the 2022 certification package.

If a County MHP is unable to comply with the time or distance standards set forth in the contract, the County MHP must submit an alternative access standard request to DHCS for review and approval.

Per 42 CFR § 438.207(b), County MHPs are required to submit network certification documentation to DHCS annually. The documentation must

demonstrate that the County MHP's provider network meets the network adequacy standards for availability and accessibility of services and offers an appropriate range of services that is adequate for the anticipated number of beneficiaries for the service area (i.e., county) and maintains a network of providers operating within the scope of practice under State law, that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of beneficiaries in the services area (i.e., county). DHCS certifies the network of each County MHP and submits assurances of adequacy to the CMS. DHCS reviews State and county-level data and information, including network data submissions by the County MHPs, to conduct an analysis of the adequacy of each County MHP's network.

DHCS reviews County MHPs' network adequacy standards documentation for County MHPs' compliance in the following areas:

I. *Time and distance standards – geographic access mapping;*
II. *Network composition and capacity;*
III. *Timely access;*
IV. *Continuity of care;*
V. *Mandatory provider types;*
VI. *Language assistance capabilities; and*
VII. *System infrastructure.*

Pursuant to 42 CFR § 438.358(b)(iv), and CA WIC § 14197.05, the External Quality Review Organization (EQRO) annually assesses each County MHP's compliance with the network adequacy standards. If DHCS determines that a County MHP does not meet the network adequacy standards, or a DHCS-approved alternate access standard, the County MHP will be required to submit a corrective action plan to DHCS demonstrating steps the County MHP will take to come into compliance with the standards. DHCS will monitor the County MHP's corrective actions and require updated information from the County MHP on a monthly basis until the County MHP meets the applicable standards.

If the County MHP is not making satisfactory progress toward compliance with applicable standards, DHCS may impose sanctions pursuant to CA WIC § 14197.7, including monetary sanctions, and the temporary withholding of payments.

Per 42 CFR § 438.207(c)(3), all County MHPs, whether under an approved alternative access standard or not, must submit documentation to DHCS, within ten business days, anytime there is a significant change in the County MHP's operations that would affect the adequacy of the County MHP's capacity or services, including a change in services, benefits, geographic service area, composition of or payments to its provider network, or enrollment of a new member population.

In addition to the network adequacy requirements, County MHPs are required to provide beneficiaries access to out-of-network providers if an in-network provider is not available within the time and distance standards. (42 CFR 438.206(b)(4); California Information Notice 21-008)

***DMC-ODS**: Under DMC-ODS, county-operated PIHPs providing coverage under the DMC-ODS program are contractually required to maintain a network of providers that is sufficient to provide beneficiaries with adequate access to all covered services. In establishing and monitoring the network, the PIHP must document the anticipated number of Medi-Cal-eligible beneficiaries, the expected utilization of services, the expected number and types of providers needed to meet anticipated utilization, and the geographic location of providers and their accessibility to beneficiaries, as well as other relevant factors identified in the Intergovernmental Agreement between the county and DHCS. In addition, the PIHP must meet and require its providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services. PIHPs must establish mechanisms to ensure that network providers comply with timely access requirements; monitor network providers regularly to determine compliance with timely access requirements; and take corrective action in response to identified noncompliance.*

In addition, PIHPs must, when requested by DHCS, demonstrate that they offer an appropriate range of SUD treatment services and a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of beneficiaries in the service area.

When a beneficiary makes a request for covered services, the PIHP must require services to be initiated with reasonable promptness and have a documented system for monitoring and evaluating the quality, appropriateness, and accessibility of care, including a system for addressing problems that develop regarding waiting times and appointments. If the PIHP is unable to provide necessary service, DHCS requires the PIHP to adequately and timely cover these services out-of-network for the beneficiary. Moreover, PIHPs must monitor accessibility of services as part of their ongoing quality assessment and performance improvement program.

DHCS also contracts with the EQRO to ensure compliance with contractual obligations and that network adequacy standards are met (including but not limited to array of services, timely access, time and distance) for the DMC-ODS plans.

2. **Details**. The State will provide enrollees with the following choices (please replicate for each program in waiver):

- **X** Two or more MCOs *(Applies to MCMC for Two Plan, GMC, Regional, and Imperial counties)*
- ___ Two or more primary care providers within one PCCM system.

___ A PCCM or one or more MCOs
___ Two or more PIHPs.
__X__ Two or more PAHPs. *(Applies to Dental MC)*
__X__ Other: (please describe) *(Applies to MCMC for COHS counties and San Benito, SMHS, DMC-ODS; Update for November 2022 1915(b) Waiver Amendment: Also applies to MCMC for Single Plan counties)* [12]

DHCS Response

***MCMC**: Six models of MCMC operate in the State, varying by county and region. In general, enrollees in non-COHS counties have a choice of MCPs. Dual eligible enrollees in certain non-COHS counties are enrolled in the MCP aligned with their choice of Medicare Advantage plan whenever possible to allow for greater integration and coordination of care. (These beneficiaries retain the ability to opt out of the aligned MCP if they choose.) These MCP choices are further described by MCMC model below.*

- *COHS: Under the COHS model, beneficiaries are served by a single plan that is created and administered by a county's board of supervisors, or other local health authority. A COHS plan must enroll all Medicaid beneficiaries residing in the county in which it operates, except when an alternative delivery system is authorized and available in the county. These single, local plans are considered Health Insuring Organizations (HIO), which are managed care delivery systems unique to California and operate under the authority of § 9517(c) of Consolidated Omnibus Budget Reconciliation Act (COBRA) 1985, which was subsequently amended by § 4734 of Omnibus Budget Reconciliation Act (OBRA) 1990 and Medicare Improvements for Patients and Providers Act (MIPAA) 2008. HIOs are exempt from the managed care requirements of § 1932 of the Act (implemented through 42 CFR § 438) because they are not subject to the requirements under § 1903(m)(2)(A) that apply to MCOs and contracts with MCOs. 42 CFR § 438.2 identifies these as county-operated entities and California State law that passed simultaneously with OBRA 1990 identifies these as COHS. Consistent with treatment under the Bridge to Reform and Medi-Cal 2020 1115 demonstrations, the Health Plan of San Mateo is considered a COHS, but is not considered an HIO by federal standards because it became operational after January 1, 1986.*

- *Two-Plan: Beneficiaries choose between a single publicly run entity known as a local initiative plan and a single commercial plan.*

[12] In COHS and Single Plan counties where Kaiser Foundation Health Plan operates as a full-risk, full-scope Medi-Cal managed care plan, Medi-Cal members will have choice of more than one managed care plan.

- *GMC: Beneficiaries choose from multiple commercial health plans.*

- *Regional: Beneficiaries choose between two or more commercial health plans.*

- *Imperial: Beneficiaries in Imperial County choose between two commercial health plans.*

- *San Benito: Beneficiaries in San Benito County choose between a single commercial plan and FFS, and enrollment in managed care is voluntary.*

Beneficiaries ages 21 and over with an AIDS diagnosis who reside in Los Angeles County also have the option to enroll in Positive Healthcare (PHC) California, a special-needs Medi-Cal managed care plan operated by the AIDS Healthcare Foundation.

DHCS Update for November 2022 Amendment

Through an amendment to the 1915(b) submitted to CMS in November 2022, DHCS is seeking authority to limit plan choice in rural counties to allow counties to participate, or continue participating, in the COHS and Single Plan models.[13]

- *COHS: Under the COHS model, beneficiaries are served by a single plan that is created and administered by a county's board of supervisors, or other local health authority. California is seeking an amendment to reflect use of the rural area exemption for rural counties in existing and expanding COHS. As noted above, DHCS had authority relating to the existing COHS to limit Medi-Cal managed care plan choice under federal law provisions*[14] *that exempt them from the otherwise applicable managed care choice requirements set forth in Section 1903(m)(2)(A) of the Social Security Act. Four of these COHS are HIOs under federal law; their statutory exemption from 1903(m)(2)(A) is conditioned on not exceeding a 16% enrollment level in those four COHS as a share of all Medi-Cal beneficiaries. Once the 16% enrollment level is exceeded, the managed care requirements in 42 CFR Part 438, including choice provisions, would*

[13] In COHS and Single Plan counties where Kaiser Foundation Health Plan operates as a full-risk, full-scope Medi-Cal managed care plan, Medi-Cal members will have choice of more than one managed care plan.

[14] SSA 1932(a)(3): requires choice of at least two MCOs, with specific exceptions including:

- COHS / HIOs that became operational prior to Jan 1, 1986;
- HIOs as outlined in Sec. 9517(c), if total membership in those HIOs is under 16% of Medi-Cal beneficiaries; and
- Rural areas if >2 physicians or case managers (if available in the area) and may go out-of-network in appropriate circumstances.

apply to all HIOs currently operating under federal statute. DHCS projects that enrollment will likely be close to or exceed the aggregate 16% level following the expansion of two of those four COHS/HIOs into new counties.

Given enrollment will be close to or in excess of the aggregate 16% level following the expansion of the COHS model, DHCS is requesting an amendment to the CalAIM 1915(b) waiver to reflect use of the rural area exemption for rural counties in existing and expanding COHS. Through a separate submission, DHCS is also seeking an amendment to its CalAIM Section 1115 Demonstration to secure expenditure authority to limit plan choice in non-rural areas for all COHS.

Single Plan: Beneficiaries are served by a single publicly run entity known as a local initiative plan or other plan operating under county authority. DHCS is requesting an amendment to the CalAIM 1915(b) waiver to reflect use of the rural area exemption for rural counties intending to operate a Single Plan. Through a separate submission, DHCS is seeking an amendment to its CalAIM Section 1115 Demonstration to secure expenditure authority to limit plan choice in Single Plan model counties in non-rural areas.

***Dental MC**: In Sacramento County, Medi-Cal child and adult enrollees receive their dental services through Dental MC. Enrollees choose from three plans.*

***SMHS**: Enrollees who meet criteria for SMHS services must receive services through their County MHP. See response in previous selection about the mechanisms DHCS has in place to assure a network of appropriate providers that is sufficient to provide adequate access to all covered services for all beneficiaries, including those with limited English proficiency or physical and mental disabilities.*

***DMC-ODS**: Enrollees who reside in a participating county and meet criteria for DMC-ODS services must receive services through the county's DMC-ODS PIHP. See response in previous selection about the mechanisms DHCS has in place to assure a network of appropriate providers that is sufficient to provide adequate access to all covered services for all beneficiaries, including those with limited English proficiency or physical and mental disabilities.*

Regardless of managed care delivery system, DHCS requires the MCO/HIO/PIHP/PAHP to ensure the availability and accessibility of adequate numbers of providers, service locations, service sites, and professional, allied, and supportive personnel to provide medically necessary services, and ensure the authorization of services for urgent conditions as outlined in federal and State statutes, regulations, and plan contracts. Beneficiaries are provided with a choice

of providers within the plans and an opportunity to change providers whenever feasible. California's network adequacy requirements, provided by CA WIC § 14197 and set forth in greater detail in All Plan Letter 20-003 and the plan contract, ensure that all beneficiaries have adequate access to all medically necessary covered services as required by 42 CFR § 438.68, 438.206, and 438.207.

Together, the foregoing network adequacy requirements and enforcement and compliance mechanisms for MCMC, Dental MC, DMC-ODS, and SMHS result in adequate access to services and quality of care, notwithstanding that beneficiaries are not provided with a choice of plans in COHS counties under MCMC, SMHS, and DMC-ODS.

3. <u>Rural Exception</u>.

_X__ The State seeks an exception for rural area residents under section 1932(a)(3)(B) of the Act and 42 CFR 438.52(b), and assures CMS that it will meet the requirements in that regulation, including choice of physicians or case managers, and ability to go out of network in specified circumstances. The State will use the rural exception in the following areas ("rural area" must be defined as any area other than an "urban area" as defined in 42 CFR 412.62(f)(1)(ii)):

<u>DHCS Update for November 2022 Amendment</u>

DHCS is requesting an amendment to the CalAIM 1915(b) waiver to reflect use of the rural area exemption for rural counties to permit DHCS to limit plan choice in existing and expanding COHS as well as rural counties intending to operate a Single Plan – these counties are identified in the revised version of Table 2 outlining MCMC entities included in this amendment.

Prior to the November 2022 amendment, DHCS had authority relating to the existing COHS to limit MCMC plan choice under federal law provisions[15] that exempt them from the otherwise applicable managed care choice requirements set forth in Section 1903(m)(2)(A) of the Social Security Act. Four of these COHS were health insuring organizations (HIOs) under federal law; their statutory exemption from 1903(m)(2)(A) is conditioned on not exceeding a 16% enrollment level in those four COHS as a share of all Medi-Cal beneficiaries. Once the 16% enrollment level is exceeded, the managed care requirements in 42 CFR Part 438, including choice provisions, would apply to all HIOs currently operating under federal statute. DHCS projects that enrollment will likely be close to or exceed the aggregate 16% level following the expansion of two of those four COHS/HIOs into new counties.

Given enrollment will be close to or in excess of the aggregate 16% level following the expansion of the COHS model, DHCS is requesting an amendment to the CalAIM 1915(b) waiver to reflect use of the rural area exemption for rural counties in existing and expanding COHS as well as rural counties intending to operate a Single Plan, and to include language memorializing the model changes.
Through a separate submission, DHCS is requesting an amendment to the CalAIM Section 1115 demonstration to include expenditure authority to limit choice of managed care plans. This expenditure authority would apply in the Metro, Large Metro, and Urban counties proposed to participate in the COHS and Single Plan models.

4. <u>1915(b)(4) Selective Contracting.</u>

___ Beneficiaries will be limited to a single provider in their service area (please define service area).
___ Beneficiaries will be given a choice of providers in their service area.

D. Geographic Areas Served by the Waiver

1. **General.** Please indicate the area of the State where the waiver program will be implemented. (If the waiver authorizes more than one program, please list applicable programs below item(s) the State checks.

   X **Statewide** -- all counties, zip codes, or regions of the State *(Applies to MCMC, SMHS)*

   X **Less than Statewide** *(Applies to Dental MC; SMHS; DMC-ODS)*

   DHCS Response

   Waivers for comparability and statewideness applicable to SMHS and DMC-ODS extend to the implementation of all services under these delivery systems.

2. **Details.** Regardless of whether item 1 or 2 is checked above, please list in the chart below the areas (i.e., cities, counties, and/or regions) and the name and type of entity or program (MCO, PIHP, PAHP, HIO, PCCM or other entity) with which the State will contract.

   DHCS Response

   MCMC:
   DHCS procured MCPs in certain counties in late 2021 to 2022, which shifted the entities operating in each county. For a summary of the MCMC entities operating in each county, please visit the DHCS website: https://www.dhcs.ca.gov/services/Pages/County-Model-Change-Information.asp.

Table 2A: MCMC Models by County until January 1, 2024

County	Managed Care Model	Type of Program	
Alameda	Two-Plan	MCO	
Alpine	Regional	MCO	
Amador	Regional	MCO	
Butte	Regional	MCO	
Calaveras	Regional	MCO	
Colusa	Regional	MCO	
Contra Costa	Two-Plan	MCO	
Del Norte	COHS	HIO	
El Dorado	Regional	MCO	
Fresno	Two-Plan	MCO	

County	Managed Care Model	Type of Program	
Glenn	Regional	MCO	
Humboldt	COHS	HIO	
Imperial	Imperial	MCO	
Inyo	Regional	MCO	
Kern	Two-Plan	MCO	
Kings	Two-Plan	MCO	
Lake	COHS	HIO	
Lassen	COHS	HIO	
Los Angeles	Two-Plan	MCO	
Madera	Two-Plan	MCO	
Marin	COHS	HIO	
Mariposa	Regional	MCO	
Mendocino	COHS	HIO	
Merced	COHS	HIO	
Modoc	COHS	HIO	
Mono	Regional	MCO	
Monterey	COHS	HIO	
Napa	COHS	HIO	
Nevada	Regional	MCO	
Orange	COHS	HIO	
Placer	Regional	MCO	
Plumas	Regional	MCO	
Riverside	Two Plan	MCO	
Sacramento	GMC	MCO	
San Benito	GMC	MCO	
San Bernardino	Two Plan	MCO	
San Diego	GMC	MCO	
San Francisco	Two Plan	MCO	
San Joaquin	Two Plan	MCO	
San Luis Obispo	COHS	HIO	
San Mateo	COHS	HIO/MCO[16]	
Santa Barbara	COHS	HIO	
Santa Clara	Two Plan	MCO	
Santa Cruz	COHS	HIO	
Shasta	COHS	HIO	
Sierra	Regional	MCO	

[16] As previously provided for under the Bridge to Reform and Medi-Cal 2020 1115 demonstrations, Health Plan of San Mateo is considered a COHS, even if it is not considered an HIO by federal standards because it became operational after January 1, 1986.

County	Managed Care Model	Type of Program	
Siskiyou	COHS	HIO	
Solano	COHS	HIO	
Sonoma	COHS	HIO	
Stanislaus	COHS	HIO	
Sutter	Regional	MCO	
Yuba	Regional	MCO	
Tehama	Regional	MCO	
Trinity	COHS	HIO	
Tulare	Two Plan	MCO	
Tuolumne	Regional	MCO	
Ventura	COHS	HIO	
Yolo	COHS	HIO	

November 2022 Amendment: *The following table outlines the models operating in each county following implementation of the MCP model changes effective January 1, 2024. For a summary of the MCMC entities operating in each county, please visit the DHCS website: https://www.dhcs.ca.gov/services/Pages/County-Model-Change-Information.aspx.*

Table 3B: MCMC Models by County as of January 1, 2024[17]

County	Managed Care Model	Type of Program
Alameda	Single Plan	MCO
Alpine	Two Plan	MCO
Amador	Regional	MCO
Butte	COHS	MCO
Calaveras	Regional	MCO
Colusa	COHS	MCO
Contra Costa	COHS	MCO
Del Norte	COHS	HIO
El Dorado	Two Plan	MCO
Fresno	Two Plan	MCO
Glenn	COHS	MCO
Humboldt	COHS	HIO
Imperial	Single Plan	MCO
Inyo	Regional	MCO
Kern	Two Plan	MCO

[17] Effective January 1, 2024, Kaiser Foundation Health Plan will also operate as a full-risk, full-scope Medi-Cal MCO in certain geographic regions of the State. Kaiser would be an option for their existing Medi-Cal enrollment in 22 counties as well as in 10 counties where Kaiser has enrollment in other lines of business for continuity of coverage. In COHS and Single Plan counties where Kaiser Foundation Health Plan operates, Medi-Cal members will have choice of more than one managed care plan.

County	Managed Care Model	Type of Program
Kings	*Two Plan*	*MCO*
Lake	*COHS*	*HIO*
Lassen	*COHS*	*HIO*
Los Angeles	*Two Plan*	*MCO*
Madera	*Two Plan*	*MCO*
Marin	*COHS*	*HIO*
Mariposa	*COHS*	*MCO*
Mendocino	*COHS*	*HIO*
Merced	*COHS*	*HIO*
Modoc	*COHS*	*HIO*
Mono	*Regional*	*MCO*
Monterey	*COHS*	*HIO*
Napa	*COHS*	*HIO*
Nevada	*COHS*	*MCO*
Orange	*COHS*	*HIO*
Placer	*COHS*	*MCO*
Plumas	*COHS*	*MCO*
Riverside	*Two Plan*	*MCO*
Sacramento	*GMC*	*MCO*
San Benito	*COHS*	*MCO*
San Bernardino	*Two Plan*	*MCO*
San Diego	*GMC*	*MCO*
San Francisco	*Two Plan*	*MCO*
San Joaquin	*Two Plan*	*MCO*
San Luis Obispo	*COHS*	*HIO*
San Mateo	*COHS*	*HIO/MCO*[18]
Santa Barbara	*COHS*	*HIO*
Santa Clara	*Two Plan*	*MCO*
Santa Cruz	*COHS*	*HIO*
Shasta	*COHS*	*HIO*
Sierra	*COHS*	*MCO*
Siskiyou	*COHS*	*HIO*
Solano	*COHS*	*HIO*
Sonoma	*COHS*	*HIO*
Stanislaus	*COHS*	*HIO*
Sutter	*COHS*	*MCO*
Yuba	*COHS*	*MCO*
Tehama	*COHS*	*MCO*

[18] As previously provided for under the Bridge to Reform and Medi-Cal 2020 1115 demonstrations, Health Plan of San Mateo is considered a COHS, even if it is not considered an HIO by federal standards because it became operational after January 1, 1986.

County	Managed Care Model	Type of Program
Trinity	COHS	HIO
Tulare	Two Plan	MCO
Tuolumne	Regional	MCO
Ventura	COHS	HIO
Yolo	COHS	HIO

Dental MC:

Table 4: Dental MC Program Types

For a summary of the Dental MC entities operating in each county, please visit the DHCS website: https://www.dhcs.ca.gov/services/Pages/County-Model-Change-Information.aspx.

County	Type of Program	
Sacramento	PAHP	

SMHS:

Table 5: SMHS Program Types

For a summary of the SMHS entities operating in each county, please visit the DHCS website: https://www.dhcs.ca.gov/services/Pages/County-Model-Change-Information.aspx.

County	Type of Program	
Alameda	PIHP	
Alpine	PIHP	
Amador	PIHP	
Butte	PIHP	
Calaveras	PIHP	
Colusa	PIHP	
Contra Costa	PIHP	
Del Norte	PIHP	
El Dorado	PIHP	
Fresno	PIHP	
Glenn	PIHP	
Humboldt	PIHP	
Imperial	PIHP	
Inyo	PIHP	
Kern	PIHP	
Kings	PIHP	
Lake	PIHP	
Lassen	PIHP	
Los Angeles	PIHP	
Madera	PIHP	

County	Type of Program	
Marin	*PIHP*	
Mariposa	*PIHP*	
Mendocino	*PIHP*	
Merced	*PIHP*	
Modoc	*PIHP*	
Mono	*PIHP*	
Monterey	*PIHP*	
Napa	*PIHP*	
Nevada	*PIHP*	
Orange	*PIHP*	
Placer/Sierra	*PIHP*	
Plumas	*PIHP*	
Riverside	*PIHP*	
Sacramento	*PIHP*	
San Benito	*PIHP*	
San Bernardino	*PIHP*	
San Diego	*PIHP*	
San Francisco	*PIHP*	
San Joaquin	*PIHP*	
San Luis Obispo	*PIHP*	
San Mateo	*PIHP*	
Santa Barbara	*PIHP*	
Santa Clara	*PIHP*	
Santa Cruz	*PIHP*	
Shasta	*PIHP*	
Siskiyou	*PIHP*	
Solano	*PIHP*	
Sonoma	*PIHP*	
Stanislaus	*PIHP*	
Sutter/Yuba	*PIHP*	
Tehama	*PIHP*	
Trinity	*PIHP*	
Tulare	*PIHP*	
Tuolumne	*PIHP*	
Ventura	*PIHP*	
Yolo	*PIHP*	

DMC-ODS:

Table 6: DMC-ODS Program Types

For a summary of the DMC-ODS entities operating in each county, please visit the DHCS website: https://www.dhcs.ca.gov/services/Pages/County-Model-Change-Information.aspx.

County	Type of Program	
Alameda	PIHP	
Contra Costa	PIHP	
El Dorado	PIHP	
Fresno	PIHP	
Humboldt (Partnership)	PIHP	
Imperial	PIHP	
Kern	PIHP	
Lassen (Partnership)	PIHP	
Los Angeles	PIHP	
Marin	PIHP	
Mendocino (Partnership)	PIHP	
Merced	PIHP	
Modoc (Partnership)	PIHP	
Monterey	PIHP	
Napa	PIHP	
Nevada	PIHP	
Orange	PIHP	
Placer	PIHP	
Riverside	PIHP	
Sacramento	PIHP	
San Benito	PIHP	
San Bernardino	PIHP	
San Diego	PIHP	
San Francisco	PIHP	
San Joaquin	PIHP	
San Luis Obispo	PIHP	
San Mateo	PIHP	
Santa Barbara	PIHP	
Santa Clara	PIHP	
Santa Cruz	PIHP	
Shasta (Partnership)	PIHP	
Siskiyou	PIHP	

County	Type of Program	
(Partnership)		
Solano (Partnership)	*PIHP*	
Stanislaus	*PIHP*	
Tulare	*PIHP*	
Ventura	*PIHP*	
Yolo	*PIHP*	

E. Populations Included in Waiver

Please note that the eligibility categories of Included Populations and Excluded Populations below may be modified as needed to fit the State's specific circumstances.

DHCS Response

A breakdown of MCMC enrollment by aid code group and MCMC model is included for reference as "Attachment II: Managed Care Enrollment Proposed Aid Code Group Coverage."

1. **Included Populations.** The following populations are included in the Waiver Program:

   _X_ **Section 1931 Children and Related Populations** are children including those eligible under Section 1931, poverty-level related groups and optional groups of older children.

   - _X_ Mandatory enrollment *(Applies to MCMC, Dental MC, SMHS, DMC-ODS)*
   - ___ Voluntary enrollment

   _X_ **Section 1931 Adults and Related Populations** are adults including those eligible under Section 1931, poverty-level pregnant women and optional group of caretaker relatives.

   - _X_ Mandatory enrollment *(Applies to MCMC, Dental MC, SMHS, DMC-ODS)*
   - ___ Voluntary enrollment

   _X_ **Blind/Disabled Adults and Related Populations** are beneficiaries, age 18 or older, who are eligible for Medicaid due to blindness or disability. Report Blind/Disabled Adults who are age 65 or older in this category, not in Aged.

__X__ Mandatory enrollment *(Applies to MCMC, Dental MC, SMHS, DMC-ODS)*
___ Voluntary enrollment

__X__ **Blind/Disabled Children and Related Populations** are beneficiaries, generally under age 18, who are eligible for Medicaid due to blindness or disability.

__X__ Mandatory enrollment *(Applies to MCMC, Dental MC, SMHS, DMC-ODS)*
___ Voluntary enrollment

__X__ **Aged and Related Populations** are those Medicaid beneficiaries who are age 65 or older and not members of the Blind/Disabled population or members of the Section 1931 Adult population.

__X__ Mandatory enrollment *(Applies to MCMC, SMHS, DMC-ODS)*
___ Voluntary enrollment

__X__ **Foster Care Children** are Medicaid beneficiaries who are receiving foster care or adoption assistance (Title IV-E), are in foster-care, or are otherwise in an out-of-home placement.

__X__ Mandatory enrollment *(Applies to MCMC in COHS counties, Dental MC, SMHS, DMC-ODS)*

DHCS Response

Although foster care children are mandatorily enrolled, if they request to disenroll, there is an expedited disenrollment process for this population under the conditions specified in Title 22, CCR, § 53889(j).

__X__ Voluntary enrollment *(Applies to MCMC in non-COHS counties)*

__X__ **TITLE XXI SCHIP** is an optional group of targeted low-income children who are eligible to participate in Medicaid if the State decides to administer the State Children's Health Insurance Program (SCHIP) through the Medicaid program.

__X__ Mandatory enrollment *(Applies to MCMC, Dental MC, SMHS, DMC-ODS)*
___ Voluntary enrollment

_X_ **Section 1902 (a)(10)(A)(i)(VIII)** Adult beneficiaries are nonpregnant adults ages 19 through 64 who are not otherwise mandatorily eligible for Medicaid and with income at or below 133 percent of the FPL.

_X_ Mandatory enrollment *(Applies to MCMC, Dental MC, SMHS, DMC-ODS)*
___ Voluntary enrollment

DHCS Response

American Indians/Alaska Natives. *In 2022, American Indians and Alaska Natives will be subject to mandatory enrollment; however American Indians and Alaska Natives residing in non-COHS counties will have the ability to opt out of MCMC for FFS.*

Dual eligible: *In 2022, DHCS will continue to require individuals dually eligible for Medi-Cal and Medicare in CCI and COHS counties to enroll in MCMC for Medi-Cal benefits, and include institutional long-term care as a managed care benefit in CCI counties. In 2023, DHCS will require dual eligible, except for individuals otherwise excluded from MCMC, such as those with a Share of Cost not in institutional Long-Term Care and other MCMC excluded populations, to enroll in MCMC statewide. For dual eligible beneficiaries who opt to enroll in a Medicare Advantage plan, including a D-SNP, DHCS will align these beneficiaries' Medi-Cal MCP enrollment with their Medicare Advantage plan enrollment whenever possible to allow for greater integration and coordination of care. DHCS plans to transition to aligned enrollment in select non-COHS counties in 2022, and will expand this approach statewide in future years.*

2. **Excluded Populations.** Within the groups identified above, there may be certain groups of individuals who are excluded from the Waiver Program. For example, the "Aged" population may be required to enroll into the program, but "Dual Eligibles" within that population may not be allowed to participate. In addition, "Section 1931 Children" may be able to enroll voluntarily in a managed care program, but "Foster Care Children" within that population may be excluded from that program. Please indicate if any of the following populations are excluded from participating in the Waiver Program:

___ **Other Insurance**--Medicaid beneficiaries who have other health insurance.

_X_ **Reside in Nursing Facility or ICF/MR--**Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Mentally Retarded (ICF/MR). *(Applies to Dental MC)*

DHCS Response

Dental MC members in Sacramento County who are enrolled in Medi-Cal Section 1915(c) waiver programs, such as Nursing Facility/Acute Hospital (NF/AH), may request a temporary medical exemption from mandatory plan enrollment. If granted, members can see their regular dentist until the complex medical condition is resolved. The temporary waiver can continue up to 12 months (or 90 days after a member gives birth).

___ **Enrolled in Another Managed Care Program**--Medicaid beneficiaries who are enrolled in another Medicaid managed care program.

___ **Eligibility Less Than 3 Months**--Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program.

_X_ **Participate in HCBS Waive**r--Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver). *(Applies to Dental MC)*

DHCS Response

Dental MC members in Sacramento County who are enrolled in Medi-Cal waiver programs, such as Home and Community Based Services (HCBS), may request a temporary medical exemption from mandatory plan enrollment. If granted, members can see their regular dentist until the complex medical condition is resolved. The temporary waiver can continue up to 12 months (or 90 days after a member gives birth).

___ **American Indian/Alaskan Native--**Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes.

___ **Special Needs Children (State Defined)--**Medicaid beneficiaries who are special needs children as defined by the State. Please provide this definition.

___ **SCHIP Title XXI Children** – Medicaid beneficiaries who receive services through the SCHIP program.

___ **Retroactive Eligibility** – Medicaid beneficiaries for the period of retroactive eligibility.

X **Other** (Please define):

DHCS Response

MCMC:

Limited aid code groups will be excluded from the waiver and receive Medi-Cal FFS. The excluded groups are:

- ***OBRA Restricted scope in Napa, Solano, and Yolo counties.*** *See description here.*
- ***Share of cost (including Trafficking and Crime Victims Assistance Program share of cost, excluding long-term care share of cost).*** *Individuals who are in medically needy Share of Cost (also referred to as an SOC) and are responsible to pay toward their medical-related services, supplies, or equipment before Medi-Cal will begin to pay.*
- ***Presumptive eligibility.*** *See description here.*
- ***State medical parole, county compassionate release, and incarcerated individuals****. See description here. As part of the pending Section 1115 demonstration renewal, California is requesting authority to provide targeted Medi-Cal services to eligible justice-involved populations 30 days pre-release; services will include Enhanced Care Management (ECM) and limited community-based clinical consultation services provided via telehealth or e-consultation, and a 30-day supply of medication for use post-release into the community.*
- ***Non-citizen pregnancy-related aid codes enrolled in Medi-Cal****. Pregnant individuals who have unsatisfactory immigration status.*
- ***Certain pregnancy-related Medi-Cal.*** *Pregnant women with incomes 138-213 percent FPL who are citizens or lawfully present will be mandatorily enrolled in MCMC starting in 2022. Pending State legislation would create a special exception for those pregnant women accessing services FFS prior to January 1, 2022 – they will be excluded from MCMC and remain in FFS through their postpartum period.*

Program of All-Inclusive Care for the Elderly (PACE). *In addition, Medi-Cal beneficiaries enrolled in a PACE will be excluded from the waiver.*[19]

___ **Medicare Dual Eligible**--Individuals entitled to Medicare and eligible for some category of Medicaid benefits. (Section 1902(a)(10) and Section 1902(a)(10)(E))

___ **Poverty Level Pregnant Women** -- Medicaid beneficiaries, who are eligible only while pregnant and for a short time after delivery. This population originally became eligible for Medicaid under the SOBRA legislation.

F. Services

List all services to be offered under the Waiver in Appendices D2.S. and D2.A of Section D, Cost-Effectiveness.

DHCS Response

DHCS has provided a breakdown of services covered by Medi-Cal's managed care delivery system programs and through FFS as Attachment III.

1. **Assurances.**

_X_ The State assures CMS that services under the Waiver Program will comply with the following federal requirements:

(Applies to MCMC, Dental MC, SMHS, DMC-ODS, except as noted below)

- Services will be available in the same amount, duration, and scope as they are under the State Plan per 42 CFR 438.210(a)(2).

  DHCS Response

  Waivers for comparability and statewideness applicable to SMHS and DMC-ODS extend to the implementation of all services under these delivery systems.

[19] The Medi-Cal 2020 Section 1115 demonstration includes language that outlines Medi-Cal beneficiaries in selected COHS counties are permitted to enroll in PACE independent of the COHS MCP. CMS has confirmed that express waiver authority is not necessary to continue this allowance under the Section 1915(b) waiver for COHS counties where a PACE plan is available.

- Access to emergency services will be assured per Section 1932(b)(2) of the Act and 42 CFR 438.114.

  DHCS Response

  Note that 42 CFR § 438.114 and 1932(b)(2) are inapplicable to SMHS and DMC-ODS.

  ***SMHS**: Emergency and post-stabilization services as defined under these provisions are not provided under SMHS. Emergency and post-stabilization services for all Medi-Cal beneficiaries are covered through the capitation payment made to MCPs. SMHS includes psychiatric inpatient hospital services, psychiatric health facilities services, crisis intervention, crisis stabilization, and crisis residential services. There are provisions for emergency admission to a psychiatric inpatient hospital; however, this is not equivalent to emergency services described in 42 CFR § 438.114.*

  ***DMC-ODS**: Emergency services are not provided in connection with DMC-ODS.*

- Access to family planning services will be assured per Section 1905(a)(4) of the Act and 42 CFR 431.51(b)

  DHCS Response

  Note that family planning services are not provided in connection with the Dental MC, SMHS, or DMC-ODS programs

___ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any. (See note below for limitations on requirements that may be waived).

X The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of 42 CFR 438.210(a)(2), 438.114, and 431.51 (Coverage of Services, Emergency Services, and Family Planning) as applicable. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

(Applies to MCMC, Dental MC, SMHS, DMC-ODS)

DHCS Response

Note that 42 CFR § 438.114 and 1932(b)(2) are inapplicable to SMHS and DMC-ODS.

***SMHS**: Emergency and post-stabilization services as defined under these provisions are not provided under SMHS. Emergency and post-stabilization services for all Medi-Cal beneficiaries are covered through the capitation payment made to MCPs. SMHS includes psychiatric inpatient hospital services, psychiatric health facilities services, crisis intervention, crisis stabilization, and crisis residential services. There are provisions for emergency admission to a psychiatric inpatient hospital; however, this is not equivalent to emergency services described in 42 CFR § 438.114.*

***DMC-ODS**: Emergency services are not provided in connection with DMC-ODS.*

___ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply. The State assures CMS that services will be available in the same amount, duration, and scope as they are under the State Plan.

X The state assures CMS that it complies with Title I of the Medicare Modernization Act of 2003, in so far as these requirements are applicable to this waiver. *(Applies to MCMC, SMHS, DMC-ODS)*

Note: Section 1915(b) of the Act authorizes the Secretary to waive most requirements of Section 1902 of the Act for the purposes listed in Sections 1915(b)(1)-(4) of the Act. However, within Section 1915(b) there are prohibitions on waiving the following subsections of Section 1902 of the Act for any type of waiver program:

- Section 1902(s) -- adjustments in payment for inpatient hospital services furnished to infants under age 1, and to children under age 6 who receive inpatient hospital services at a Disproportionate Share Hospital (DSH) facility.
- Sections 1902(a)(15) and 1902(bb) – prospective payment system for FQHC/RHC
- Section 1902(a)(10)(A) as it applies to 1905(a)(2)(C) – comparability of FQHC benefits among Medicaid beneficiaries
- Section 1902(a)(4)(C) – freedom of choice of family planning providers
- Sections 1915(b)(1) and (4) also stipulate that Section 1915(b) waivers may not waive freedom of choice of emergency services providers.

2. **Emergency Services.** In accordance with Sections 1915(b) and 1932(b) of the Act, and 42 CFR 431.55 and 438.114, enrollees in an MCO, PIHP, PAHP, or

PCCM must have access to emergency services without prior authorization, even if the emergency services provider does not have a contract with the entity.

_**X**_ The PIHP, PAHP, or FFS Selective Contracting program does not cover emergency services. *(Applies to SMHS, DMC-ODS)*

DHCS Response
Note that 42 CFR § 438.114 and 1932(b)(2) are inapplicable to SMHS and DMC-ODS.

***SMHS**: Emergency and post-stabilization services as defined under these provisions are not provided under SMHS. Emergency and post-stabilization services for all Medi-Cal beneficiaries are covered through the capitation payment made to MCPs. SMHS includes psychiatric inpatient hospital services, psychiatric health facilities services, crisis intervention, crisis stabilization, and crisis residential services. There are provisions for emergency admission to a psychiatric inpatient hospital; however, this is not equivalent to emergency services described in 42 CFR § 438.114.*

***DMC-ODS**: Emergency services are not provided in connection with DMC-ODS.*

3. **Family Planning Services**. In accordance with sections 1905(a)(4) and 1915(b) of the Act, and 42 CFR 431.51(b), prior authorization of, or requiring the use of network providers for family planning services is prohibited under the waiver program. Out-of-network family planning services are reimbursed in the following manner:

_**X**_ The MCO/PIHP/PAHP will be required to reimburse out- of-network family planning services *(Applies to MCMC)*

___ The MCO/PIHP/PAHP will be required to pay for family planning services from network providers, and the State will pay for family planning services from out-of-network providers

___ The State will pay for all family planning services, whether provided by network or out-of-network providers.

___ Other (please explain):

_**X**_ Family planning services are not included under the waiver. *(Applies to Dental MC, SMHS, DMC-ODS)*

4. **FQHC Services**. In accordance with section 2088.6 of the State Medicaid Manual, access to Federally Qualified Health Center (FQHC) services will be assured in the following manner:

___ The program is **voluntary**, and the enrollee can disenroll at any time if he or she desires access to FQHC services. The MCO/PIHP/PAHP/PCCM is not required to provide FQHC services to the enrollee during the enrollment period.

X The program is **mandatory** and the enrollee is guaranteed a choice of at least one MCO/PIHP/PAHP/PCCM which has at least one FQHC as a participating provider. If the enrollee elects not to select a MCO/PIHP/PAHP/PCCM that gives him or her access to FQHC services, no FQHC services will be required to be furnished to the enrollee while the enrollee is enrolled with the MCO/PIHP/PAHP/PCCM he or she selected. Since reasonable access to FQHC services will be available under the waiver program, FQHC services outside the program will not be available. Please explain how the State will guarantee all enrollees will have a choice of at least one MCO/PIHP/PAHP/PCCM with a participating FQHC: *(Applies to MCMC)*

DHCS Response

Per CA WIC § 14087.325, MCPs must attempt to contract with each FQHC in their service area, where available. MCPs must annually demonstrate they are contracted with FQHCs. If an MCP is unable to contract with an FQHC, it must submit documentation to the State detailing the reasons the MCP was unable to contract with the FQHC. In accordance with CMS State Health Official letter #16-006, MCOs are required to contract with at least one FQHC in their service area, if available. MCPs are required to annually demonstrate to the State efforts to improve access to FQHCs.

___ The program is **mandatory** and the enrollee has the right to obtain FQHC services **outside** this waiver program through the regular Medicaid Program.

5. **EPSDT Requirements.**

X The managed care programs(s) will comply with the relevant requirements of sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements including informing, reporting, etc.), and 1905(r) (definition) of the Act related to Early, Periodic Screening, Diagnosis, and Treatment (EPSDT) program. *(Applies to MCMC, Dental MC, SMHS, DMC-ODS)*

6. **1915(b)(3) Services**.

_ This waiver includes 1915(b)(3) expenditures. The services must be for medical or health-related care, or other services as described in 42 CFR Part 440, and are subject to CMS approval. Please describe below what these expenditures are for each waiver program that offers them. Include a description of the populations eligible, provider type, geographic availability, and reimbursement method.

7. **Self-referrals.**

_X_ The State requires MCOs/PIHPs/PAHPs/PCCMs to allow enrollees to self-refer (i.e., access without prior authorization) under the following circumstances or to the following subset of services in the MCO/PIHP/PAHP/PCCM contract: *(Applies to MCMC, Dental MC, SMHS, DMC-ODS)*

DHCS Response

***MCMC**: The MCP contract prohibits plans from requiring prior authorization for emergency services, family planning services, preventive services, some mental health services, basic prenatal care, sexually transmitted disease services, or HIV testing.*

***Dental MC**: The GMC-Sacramento contract prohibits Dental MC plans from requiring prior authorization for emergency services.*

***SMHS**: Referrals to the County MHP for SMHS may be received through beneficiary self-referral or through referral by another person or organization, including but not limited to any health care providers, schools, county welfare departments, other County MHPs, conservators, guardians, family members, and law enforcement agencies. County MHPs may not deny an initial screening process or assessment to determine whether a beneficiary meets criteria for receiving services from the County MHP; however, the County MHP may require beneficiaries to request these initial assessments through a formal system at the County MHP. County MHP informing materials provide beneficiaries with the information needed to obtain services from the County MHP.*

***DMC-ODS**: Under the DMC-ODS program, prior authorization is not required for any non-residential DMC-ODS services.*

Section A: Program Description

Part II: Access

Each State must ensure that all services covered under the State plan are available and accessible to enrollees of the 1915(b) Waiver Program. Section 1915(b) of the Act prohibits restrictions on beneficiaries' access to emergency services and family planning services.

A. Timely Access Standards

1. Assurances for MCO, PIHP, or PAHP programs.

X The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services; in so far as these requirements are applicable. *(Applies to MCMC, Dental MC SMHS, DMC-ODS)*

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

DHCS Response

Please note that 42 CFR § 438.206(b)(2) (Women's Health Services) does not apply to DMC-ODS or SMHS since these services are not provided through DMC-ODS waiver or SMHS waiver.

X The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM. *(Applies to MCMC, Dental MC, SMHS, DMC-ODS)*

If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II.B. Capacity Standards.

2. **Details for PCCM program.** The State must assure that Waiver Program enrollees have reasonable access to services. Please note below the activities the State uses to assure timely access to services.

   a. ___ Availability Standards. The State's PCCM Program includes established maximum distance and/or travel time requirements, given beneficiary's normal means of transportation, for waiver enrollees' access to the following providers. For each provider type checked, please describe the standard.

      1.___ PCPs (please describe):

      2.___ Specialists (please describe):

      3.___ Ancillary providers (please describe):
      4.___ Dental (please describe):

      5.___ Hospitals (please describe):

      6.___ Mental Health (please describe):

      7.___ Pharmacies (please describe):

      8.___ Substance Abuse Treatment Providers (please describe):

      9.___ Other providers (please describe):

   b. ___ **Appointment Scheduling** means the time before an enrollee can acquire an appointment with his or her provider for both urgent and routine visits. The State's PCCM Program includes established standards for appointment scheduling for waiver enrollee's access to the following providers.

      1.___ PCPs (please describe):

      2.___ Specialists (please describe):

      3.__ Ancillary providers (please describe):

      4.___ Dental (please describe):

      5.___ Mental Health (please describe):

      6.___ Substance Abuse Treatment Providers (please describe):

      7.___ Urgent care (please describe):

8.___ Other providers (please describe):

c. ___ **In-Office Waiting Times**: The State's PCCM Program includes established standards for in-office waiting times. For each provider type checked, please describe the standard.

1.___ PCPs (please describe):

2.___ Specialists (please describe):

3.___ Ancillary providers (please describe):

4.___ Dental (please describe):

5.___ Mental Health (please describe):

6.___ Substance Abuse Treatment Providers (please describe):

7.___ Other providers (please describe):

d. ___ Other Access Standards (please describe)

3. **<u>Details for 1915(b)(4) FFS selective contracting programs</u>**: Please describe how the State assures timely access to the services covered under the selective contracting program.

B. Capacity Standards

1. <u>Assurances for MCO, PIHP, or PAHP programs</u>.

_X_ The State assures CMS that it complies with section 1932(b)(5) of the Act and 42 CFR 438.207 Assurances of adequate capacity and services, in so far as these requirements are applicable. *(Applies to MCMC, Dental MC, SMHS, DMC-ODS)*

___ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

_X_ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(b)(5) and 42 CFR 438.207 Assurances of adequate capacity and services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM. *(Applies to MCMC, Dental MC, SMHS, DMC-ODS)*

If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II, C. Coordination and Continuity of Care Standards.

2. <u>Details for PCCM program</u>. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below which of the strategies the State uses assure adequate provider capacity in the PCCM program.

a.___ The State has set enrollment limits for each PCCM primary care provider. Please describe the enrollment limits and how each is determined.

b.___ The State ensures that there are adequate number of PCCM PCPs with open panels. Please describe the State's standard.

c.___ The State ensures that there is an adequate number of PCCM PCPs under the waiver assure access to all services covered under the Waiver. Please describe the State's standard for adequate PCP capacity.

d.___ The State compares numbers of providers before and during the Waiver. Please modify the chart below to reflect your State's PCCM program and complete the following.

Providers	# Before Waiver	# In Current Waiver	# Expected in Renewal
Pediatricians			
Family Practitioners			
Internists			
General Practitioners			
OB/GYN and GYN			
FQHCs			
RHCs			
Nurse Practitioners			
Nurse Midwives			
Indian Health Service Clinics			
Additional Types of Provider to Be in PCCM			
1			
2.			
3.			
4.			

*Please note any limitations to the data in the chart above here:

e.___ The State ensures adequate **geographic distribution** of PCCMs. Please describe the State's standard.

f.___ **PCP: Enrollee Ratio**. The State establishes standards for PCP to enrollee ratios. Please calculate and list below the expected average PCP/Enrollee ratio for each area or county of the program, and then provide a statewide average. Please note any changes that will occur due to the use of physician extenders.

Area(City/County/Region)	*PCCM-to-Enrollee Ratio*

Statewide Average: (e.g. 1:500 and 1:1,000)	

g. ___ **Other capacity standards** (please describe):

3. **<u>Details for 1915(b)(4) FFS selective contracting programs</u>:** Please describe how the State assures provider capacity has not been negatively impacted by the selective contracting program. Also, please provide a detailed capacity analysis of the number of beds (by type, per facility) – for facility programs, or vehicles (by type, per contractor) – for non-emergency transportation programs, needed per location to assure sufficient capacity under the waiver program. This analysis should consider increased enrollment and/or utilization expected under the waiver.

C. Coordination and Continuity of Care Standards

1. Assurances For MCO, PIHP, or PAHP programs.

_X_ The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.208 Coordination and Continuity of Care, in so far as these regulations are applicable. *(Applies to MCMC, Dental MC, SMHS, DMC-ODS)*

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

DHCS Response

Please note that 42 CFR § 438.208(b)(3) does not apply to SMHS and 42 CFR § 438.208(c) does not apply to SMHS and DMC-ODS.

_X_ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.208 Coordination and Continuity of Care. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.*(Applies to MCMC, Dental MC, SMHS, DMC-ODS)*

2. Details on MCO/PIHP/PAHP enrollees with special health care needs.

The following items are required.

a. **X** The plan is a PIHP/PAHP, and the State has determined that based on the plan's scope of services, and how the State has organized the delivery system, that **the PIHP/PAHP need not meet the requirements** for additional services for enrollees with special health care needs in 42 CFR 438.208. Please provide justification for this determination. *(Applies to SMHS, DMC-ODS)*

DHCS Response

***SMHS**: There is no difference in the provision of services for special needs populations and any other covered population. All beneficiaries must meet the State criteria for accessing SMHS.*

***DMC-ODS**: There is no difference in the provision of services for special needs populations and any other covered population. All beneficiaries must meet the State criteria for accessing DMC-ODS services.*

b. **X** **Identification.** The State has a mechanism to identify persons with special health care needs to MCOs, PIHPs, and PAHPs, as those persons are defined by the State. Please describe. *(Applies to MCMC, Dental MC)*

DHCS Response

***MCMC and Dental MC:** The State provides MCPs and Dental MC plans with enrollment files that include the aid codes associated with each newly enrolled beneficiary. For beneficiaries enrolling in managed care from FFS, the MCPs and Dental MC plans also receive the beneficiary's FFS utilization data. The aid code and FFS utilization data, if provided, are used by plans to identify individuals as seniors, persons with disabilities, or persons with other special health care needs.*

c. **X** **Assessment.** Each MCO/PIHP/PAHP will implement mechanisms, using appropriate health care professionals, to assess each enrollee identified by the State to identify any ongoing special conditions that require a course of treatment or regular care monitoring. Please describe. *(Applies to MCMC, Dental MC)*

DHCS Response

***MCMC**: Each MCP is contractually required to provide case management services to all members at a level appropriate to their need including basic case management, complex case management and, with the implementation of CalAIM, Enhanced Care Management (ECM).*

Basic case management must be provided by the primary care provider, in collaboration with the MCP, which includes an initial health assessment in which a provider of primary care services can 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. Each MCP must apply a State-approved health

risk stratification mechanism or algorithm to identify newly enrolled seniors and persons with disabilities with higher risk and more complex health care needs within 44 days of enrollment.

Upon the enrollment of a beneficiary who is a senior or person with disabilities (SPD), each MCP must 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.

In addition, each MCP must develop methods to identify enrollees who may benefit from complex case management services, using the risk stratification and health risk assessment results as well as utilization and clinical data and any other available information across medical, LTSS, and behavioral health domains, as well as self and provider referrals.

Each MCP is also required to implement and maintain a program for Children with Special Health Care Needs (CSHCN). CSHCN are defined by the State as those who have or are at increased risk for a chronic physical, behavioral, developmental, or emotional condition and who require health or related services of a type or amount beyond that required by children generally. Each MCP's CSHCN program is required to include standardized procedures for identifying CSHCN at enrollment and on a periodic basis after enrollment. Members identified as CSHCN must receive comprehensive assessment of health and related needs. The MCP must implement methods for monitoring and improving the quality and appropriateness of care for CSHCN.

A key feature of CalAIM is the introduction of the statewide availability of ECM in MCMC. MCPs will be responsible for administering ECM. ECM will address the clinical and non-clinical needs of high-need, high-cost Medi-Cal members through systematic coordination of services and comprehensive care management. ECM is part of a broader population health system design within CalAIM, under which MCPs will risk stratify their enrolled populations and offer a menu of care management interventions at different levels of intensity, with ECM at the highest intensity level. ECM will be implemented on a phased basis beginning in January 2022, ahead of broader population health requirements, which will start in 2023. DHCS has identified seven mandatory ECM "populations of focus." MCPs must proactively identify their high-need, high-cost members who meet the populations of focus criteria and offer them ECM. More information about ECM is available here.

Dental MC: *Dental MC plans are contractually obligated to provide basic case management services to each member and to monitor the coordination of care provided to members. The dental plans are also required to implement and maintain a program for CSHCN, which includes standardized procedures such as dental care provider training for the identification of CSHCN at and after enrollment. Members identified as CSHCN receive comprehensive oral assessment and a written dental treatment plan. The dental plans are required to implement methods for monitoring and improving the quality and appropriateness of care for CSHCN.*

d. **X** **Treatment Plans.** For enrollees with special health care needs who need a course of treatment or regular care monitoring, the State requires the MCO/PIHP/PAHP to produce a treatment plan. If so, the treatment plan meets the following requirements:
(Applies to MCMC, Dental MC)

1. **X** Developed by enrollees' primary care provider with enrollee participation, and in consultation with any specialists' care for the enrollee

2. **X** Approved by the MCO/PIHP/PAHP in a timely manner (if approval required by plan)

3. **X** In accord with any applicable State quality assurance and utilization review standards.

e. **X** Direct access to specialists. If treatment plan or regular care monitoring is in place, the MCO/PIHP/PAHP has a mechanism in place to allow enrollees to directly access specialists as appropriate for enrollee's condition and identified needs. *(Applies to MCMC, Dental MC)*

3. Details for PCCM program. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below the strategies the State uses assure coordination and continuity of care for PCCM enrollees.

a. ___ Each enrollee selects or is assigned to a primary care provider appropriate to the enrollee's needs.

b. ___ Each enrollee selects or is assigned to a designated health care practitioner who is primarily responsible for coordinating the enrollee's overall health care.

c. ___ Each enrollee is receives health education/promotion information. Please explain.

d. ___ Each provider maintains, for Medicaid enrollees, health records that meet the requirements established by the State, taking into account professional standards.

e. ___ There is appropriate and confidential exchange of information among providers.

f. ___ Enrollees receive information about specific health conditions that require follow-up and, if appropriate, are given training in self-care.

g. ___ Primary care case managers address barriers that hinder enrollee compliance with prescribed treatments or regimens, including the use of traditional and/or complementary medicine.

h. ___ Additional case management is provided (please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case manager's files).

i. ___ Referrals: Please explain in detail the process for a patient referral. In the description, please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case managers' files.

4. **Details for 1915(b)(4) only programs**: If applicable, please describe how the State assures that continuity and coordination of care are not negatively impacted by the selective contracting program.

Section A: Program Description

Part III: Quality

1. Assurances for MCO or PIHP programs.

X The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR ~~438.202, 438.204,~~ 438.210, 438.214, ~~438.218,~~ 438.224, ~~438.226,~~ 438.228, 438.230, 438.236, ~~438.240,~~ and 438.242 in so far as these regulations are applicable. *(Applies to MCMC, Dental MC, SMHS, DMC-ODS)*

___ The State seeks a ~~waiver of a~~ waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

DHCS Response

The text stricken out above are regulatory sections that are outdated and no longer exist in the regulatory code, or appear to be typographical errors in the pre-print template.

X The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of Section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR ~~438.202, 438.204,~~ 438.210, 438.214, ~~438.218,~~ 438.224, ~~438.226~~, 438.228, 438.230, 438.236, ~~438.240,~~ and 438.242. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM. *(Applies to MCMC, Dental MC, SMHS, DMC-ODS)*

DHCS Response

The regulatory sections stricken out above are outdated and no longer exist in the regulatory code.

X 1932(c)(1)(A)(iii)-(iv) of the Act ~~and 42 CFR 438.202~~ requires that each State Medicaid agency that contracts with MCOs and PIHPs submit to CMS a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs. The State

assures CMS that this quality strategy was initially submitted to the CMS Regional Office on ***July 2, 2018*** *(Applies to MCMC, SMHS, DMC-ODS)*

DHCS Response

In 2018, DHCS wrote the Medi-Cal Managed Care Quality Strategy Report in response to this requirement. To update this report, DHCS combined updates from the Medi-Cal Managed Care Quality Strategy Report with updates and revisions to the DHCS Strategy for Quality Improvement in Health Care Report, and created the DHCS Services Comprehensive Quality Strategy (CQS) report. The CQS outlines the Department's process for developing and maintaining a broader quality strategy to assess the quality of care that all of our beneficiaries receive, regardless of delivery system, and defines measurable goals and tracks improvement while adhering to the regulatory managed care requirements of 42 CFR § 438.340. The CQS covers all Medi-Cal managed care delivery systems, including the Medi-Cal MCPs, County MHPs, DMC-ODS plans, and the Dental MC plans, as well as non-managed care departmental programs. The report also highlights delivery system reform; the coordination of efforts to improve performance on behavioral health CMS Core Set Measures; and proposed CalAIM changes. The DHCS CQS has been revised based on comments received from the public, but finalization of the CQS has been delayed to allow inclusion of additional details related to COVID-19 and the resulting CalAIM implementation delay. DHCS plans to finalize and submit the final CQS to CMS in 2021. The 2018 DHCS CQS Reports and 2019 proposed CQS Report are available here.

DHCS is working on revising and submitting its 2020 Quality Strategy to CMS. CMS has previously reviewed and provided feedback on DHCS's previous draft from November 2019 which was posted for public comment here. Given the significant impact of the COVID19 pandemic, DHCS is significantly revising its quality strategy and aims to solicit additional public feedback in November 2021 before submitting to CMS. An updated link will be provided to CMS once the review Quality Strategy draft is released.

X The State assures CMS that it complies with Section 1932(c)(2) of the Act and 42 CFR 438 Subpart E, to arrange for an annual, independent, external quality review of the outcomes and timeliness of, and access to the services delivered under each MCO/ PIHP contract. Note: EQR for PIHPs is required beginning March 2004. Please provide the information below (modify chart as necessary):
(Applies to MCMC, Dental MC, SMHS, DMC-ODS)

DHCS Response

Table 7: External Quality Review (EQR) Activities

Program	Name of Organization	Activities To Be Conducted 2022 - 2026		
		EQR Study	Mandatory Activities	Optional Activities
MCMC	*Health Services Advisory Group, Inc.*	✓	• *Assessment of the MCMC quality strategy* • *Compliance reviews of MCPs, including follow-up on audits and corrective action plans* • *Assessment of Performance Improvement Projects* • *Calculation and validation of performance measures for MCPs, analysis of trends across years (when available), and follow-up on corrective action plans* • *Follow-up on the EQRO's prior year's recommendations, both to DHCS and to MCPs* *The EQRO is also contracted to validate network adequacy as specified under 42 CFR §438.358(b)(1)(iv); however, CMS has not yet provided the protocols for this activity, so the EQRO cannot yet provide an assessment.* *The State also mandates the following EQR activities:* • *Alternative Access Standards (Network Adequacy) CA WIC §*	• *Validation of encounter data submitted by MCPs (conducted at least every three years)* • *Administration and validation of Consumer Surveys: CAHPS Medicaid Adult & Child Survey and CHIP Women & Child Statewide Survey* • *Administration of focused studies: Studies active as of April 2021 are Health Disparities; Statewide Network Analysis; Network Hot Spots; Population Needs Assessment* • *Technical assistance to MCPs on quality improvement topics through calls, webinars, and email support and*

Program	Name of Organization	Activities To Be Conducted 2022 - 2026		
		EQR Study	Mandatory Activities	Optional Activities
			14197.05(a)(b) and (d) • *Skilled Nursing Facility/Intermediate Care Facility (Network Adequacy) CA WIC § 14197.05(c) and (d)*	*annual quality conference* *The EQRO is also contracted to provide assistance with quality rating of MCPs consistent with 42 CFR § 438.334; however, CMS has not yet provided protocols for this activity, so the EQRO cannot yet provide an assessment.*
Dental Managed Care	*Health Services Advisory Group, Inc.*	✓	• *Validation of performance improvement projects* • *Calculation and validation of Dental MC plan performance measures* • *Compliance reviews of Dental MC plans* • *Validation of Dental MC plan network adequacy*	
SMHS	*Behavioral Health Concepts (contract through June 2022). To be extended until June 2024 and re-bid during Section 1915(b) waiver period.*	✓	• *Validation of Performance Improvement Projects* • *Validation of County MHP performance measures* • *Compliance reviews of County MHPs* • *Validation of MHP network adequacy*	• *Validation of encounter data reported by County MHP* • *Validation of consumer satisfaction surveys* • *Technical assistance to County MHPs through participation in Statewide Quality Improvement Coordinator meetings*

Program	Name of Organization	Activities To Be Conducted 2022 - 2026		
		EQR Study	Mandatory Activities	Optional Activities
				• *Conduct additional Performance Improvement Projects or focused studies*
DMC-ODS	*Behavioral Health Concepts (has contract through June 2022). To be extended until June 2024 and re-bid during Section 1915(b) waiver period.*	✓	• *Validation of Performance Improvement Projects* • *Validation of DMC-ODS plan performance measures* • *Compliance reviews of DMC-ODS plans* • *Validation of DMC-ODS plan network adequacy*	• *Validation of encounter data reported by DMC-ODS plan* • *Validation of Treatment Perception Surveys* • *Conduct additional Performance Improvement Projects or focused studies* • *Technical assistance to DMC-ODS plans*

2. <u>Assurances For PAHP program</u>.

<u>X</u> The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236, in so far as these regulations are applicable. *(Dental MC)*

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

<u>X</u> The CMS Regional Office has reviewed and approved the PAHP contracts for compliance with the provisions of section 1932(c) (1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236. If this is an initial waiver, the State assures that

contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM. *(Dental MC)*

3. **Details for PCCM program**. The State must assure that Waiver Program enrollees have access to medically necessary services of adequate quality. Please note below the strategies the State uses to assure quality of care in the PCCM program.

   a. ___ The State has developed a set of overall quality **improvement guidelines** for its PCCM program. Please attach.

   b. ___ **State Intervention**: If a problem is identified regarding the quality of services received, the State will intervene as indicated below. Please check which methods the State will use to address any suspected or identified problems.

      1.___ Provide education and informal mailings to beneficiaries and PCCMs;

      2.___ Initiate telephone and/or mail inquiries and follow-up;

      3.___ Request PCCM's response to identified problems;

      4.___ Refer to program staff for further investigation;

      5.___ Send warning letters to PCCMs;

      6.___ Refer to State's medical staff for investigation;

      7.___ Institute corrective action plans and follow-up;

      8.___ Change an enrollee's PCCM;

      9.___ Institute a restriction on the types of enrollees;

      10.___ Further limit the number of assignments;

      11.___ Ban new assignments;

      12.___ Transfer some or all assignments to different PCCMs;

      13.___ Suspend or terminate PCCM agreement;

      14.___ Suspend or terminate as Medicaid providers; and

15.___ Other (explain):

c. ___ **Selection and Retention of Providers:** This section provides the State the opportunity to describe any requirements, policies or procedures it has in place to allow for the review and documentation of qualifications and other relevant information pertaining to a provider who seeks a contract with the State or PCCM administrator as a PCCM. This section is required if the State has applied for a 1915(b)(4) waiver that will be applicable to the PCCM program.

Please check any processes or procedures listed below that the State uses in the process of selecting and retaining PCCMs. The State (please check all that apply):

1. ___ Has a documented process for selection and retention of PCCMs (please submit a copy of that documentation).

2. ___ Has an initial credentialing process for PCCMs that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.

3. ___ Has a recredentialing process for PCCMs that is accomplished within the time frame set by the State and through a process that updates information obtained through the following (check all that apply):

   A. ___ Initial credentialing

   B. ___ Performance measures, including those obtained through the following (check all that apply):

      ___ The utilization management system.
      ___ The complaint and appeals system.
      ___ Enrollee surveys.
      ___ Other (Please describe).

4. ___ Uses formal selection and retention criteria that do not discriminate against particular providers such as those who serve high risk populations or specialize in conditions that require costly treatment.

5. ___ Has an initial and recredentialing process for PCCMs other than individual practitioners (e.g., rural health clinics, federally qualified health centers) to ensure that they are and remain in

compliance with any Federal or State requirements (e.g., licensure).

6. ___ Notifies licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of PCCMs take place because of quality deficiencies.

7. __ Other (please describe).

d. ___ **Other quality standards** (please describe):

4. **Details for 1915(b)(4) only programs**: Please describe how the State assures quality in the services that are covered by the selective contracting program. Please describe the provider selection process, including the criteria used to select the providers under the waiver. These include quality and performance standards that the providers must meet. Please also describe how each criteria is weighted:

Section A: Program Description

Part IV: Program Operations

A. Marketing

Marketing includes indirect MCO/PIHP/PAHP or PCCM administrator marketing (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general) and direct MCO/PIHP/PAHP or PCCM marketing (e.g., direct mail to Medicaid beneficiaries).

1. Assurances

_X_ The State assures CMS that it complies with section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities; in so far as these regulations are applicable. *(Applies to MCMC, Dental MC)*

DHCS Response

The requirements at the Act § 1932(d)(2) and 42 CFR § 438.104 related to marketing are not applicable to SMHS and DMC-ODS since there is no choice of plan.

_____ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

_X_ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM. *(Applies to MCMC, Dental MC)*

___ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

2. Details

a. Scope of Marketing

1.___ The State does not permit direct or indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers .

2. **X** The State permits indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general). Please list types of indirect marketing permitted. *(Applies to MCMC, Dental MC)*

DHCS Response

MCPs and Dental MC plans are permitted to engage in media advertising, and make printed, illustrated, or videotaped materials available to members or prospective members by posting materials in public places, by participating in organized community or neighborhood health fairs, at through health care options presentations sponsored by the State. See 22 CCR § 53880. All marketing martials, including printed materials, must be approved by the State in writing prior to distribution. CA WIC § 14408. In addition, each MCP and Dental MC plan must submit a marketing plan for review and approval on an annual basis. Id.

MCPs and Dental MC plans are prohibited from conducting door-to-door, cold call, and telephone marketing activities for the purposes of enrolling current or potential Medi-Cal beneficiaries.

3.___ The State permits direct marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., direct mail to Medicaid beneficiaries). Please list types of direct marketing permitted.

b. Description. Please describe the State's procedures regarding direct and indirect marketing by answering the following questions, if applicable.

1. **X** The State prohibits or limits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers from offering gifts or other incentives to potential enrollees. Please explain any limitation or prohibition and how the State monitors this. *(Applies to MCMC, Dental MC)*

2.___ The State permits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers to pay their marketing representatives based on the number of new Medicaid enrollees he/she recruited into the plan. Please explain how the State monitors marketing to ensure it is not coercive or fraudulent:

3. **X** The State requires MCO/PIHP/PAHP/PCCM/selective contracting FFS providers to translate marketing materials into the languages

listed below (If the State does not translate or require the translation of marketing materials, please explain):

(Applies to MCMC, Dental MC)

The State has chosen these languages because (check any that apply):

i.__ The languages comprise all prevalent languages in the service area. Please describe the methodology for determining prevalent languages.

ii.__ The languages comprise all languages in the service area spoken by approximately ___ percent or more of the population.

iii. **X** Other (please explain):

DHCS Response

MCPs and Dental MC plans must provide fully translated member information, including but not limited to marketing information, in all prevalent non-English languages in the service area, consisting of the primary language of 3,000 beneficiaries or five percent of the beneficiary population in the service area (whichever is lower), as well as any language identified as a primary language of a population that meets the concentration standards of 1,000 individuals in a single ZIP code or 1,500 individuals in two contiguous ZIP codes.

B. Information to Potential Enrollees and Enrollees

1. Assurances.

_X_ The State assures CMS that it complies with Federal Regulations found at section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements; in so far as these regulations are applicable. *(Applies to MCMC, Dental MC, SMHS, DMC-ODS)*

_X_ The State seeks a ~~waiver of~~ a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any. *(Applies to SMHS, DMC-ODS)*

DHCS Response

42 CFR § 438.10(g)-(h): *DHCS requests a waiver of 42 CFR § 438.10(g)-(h), which establishes specific requirements for the types, content and distribution of information describing the SMHS and DMC-ODS programs. This allows County MHPs to provide informing materials and provider lists that meet the content requirements of § 438.10 to beneficiaries when they first access SMHS through the County MHP and on request and DMC-ODS to provide informing materials and provider lists that meet the content requirements of § 438.10 to beneficiaries when they first access SUD services through the DMC-ODS and on request. The waiver of subsections (g)-(h) would apply to the distribution requirements of the subsection only, not to any other provisions of the subsection except as directly related to the issue of distribution. CMS previously approved a waiver of this regulatory provision as 42 CFR § 438.10(f)(3) (prior to amendments made through CMS' 2016 Medicaid managed care rule) in California's SMHS Section 1915(b) waiver and Medi-Cal 2020 Section 1115 demonstration. To the extent necessary, the continuation of waivers previously granted are requested of all sections of the federal regulations that mention the obligation to inform all enrollees, to instead allow informing of all beneficiaries on request and/or when a beneficiary first accesses SMHS though a County MHP, or SUD services through DMC-ODS.*

42 CFR § 438.10(i): *DHCS requests a waiver of 42 CFR § 438.10(i), which establishes specific requirements for the types, content and distribution of information describing DMC-ODS. This allows the DMC-ODS plan to provide informing materials and*

provider lists that meet the content requirements of § 438.10 to beneficiaries when they first access SUD services through the DMC-ODS and on request. The waiver of subsection (i) would apply to the distribution requirements of the subsection only, not to any other provisions of the subsection except as directly related to the issue of distribution. CMS previously approved a waiver of this regulatory provision as 42 CFR § 438.10(f)(3) (prior to amendments made through CMS' 2016 Medicaid managed care rule) in California's Medi-Cal 2020 Section 1115 demonstration. To the extent necessary, the continuation of waivers previously granted are requested of all sections of the federal regulations that mention the obligation to inform all enrollees, to instead allow informing of all beneficiaries on request and/or when a beneficiary first accesses SUD services through DMC-ODS

The text stricken out above appears to be a typographical error in the pre-print template.

X The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM. *(Applies to MCMC, Dental MC, SMHS, DMC-ODS)*

___ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

2. Details.

a. **Non-English Languages**

X Potential enrollee and enrollee materials will be translated into the prevalent non-English languages listed below (If the State does not require written materials to be translated, please explain): *(Applies to MCMC, Dental MC, SMHS, DMC-ODS)*

The State defines prevalent non-English language as: (check any that apply):

1.__ The languages spoken by significant number of potential enrollees and enrollees. Please explain how the State defines "significant."

2. __ The languages spoken by approximately ___ percent or more of the potential enrollee/ enrollee population.

3. **X** *(Applies to MCMC, Dental MC, SMHS, DMC-ODS)*
Other (please explain):

DHCS Response

MCMC, Dental MC, and DMC-ODS*: The prevalent non-English languages consist of any languages identified as the primary language of 3,000 beneficiaries or five percent of the beneficiary population residing in the service area (whichever is lower), as well as any language identified as a primary language of a population that meets the concentration standards of 1,000 individuals in a single ZIP code or 1,500 individuals in two contiguous ZIP codes.*

SMHS*: The prevalent non-English languages consist of any languages identified as the primary language of 3,000 beneficiaries or five percent of the beneficiary population in the service area (whichever is lower). They are referred to in the SMHS program as "threshold languages."*

X Please describe how **oral translation services** are available to all potential enrollees and enrollees, regardless of language spoken.

DHCS Response

MCPs, Dental MC plans, County MHPs, and DMC-ODS plans are required to provide access to oral translation services through in-person interpreter, telephone language services, or video remote interpreting services. Oral translation must be available in all languages spoken by Medi-Cal members and potential enrollees and include auxiliary aids such as TTY/TDY and American Sign Language. Plan members/beneficiaries are able to access oral translation services 24 hours a day, 7 days a week, without charge to the member, at key points of contact.

X The State will have a **mechanism** in place to help enrollees and potential enrollees understand the managed care program. Please describe.

DHCS Response

MCMC and Dental MC*: DHCS has a robust program in place to help enrollees and potential enrollees understand the managed care program. The program, known as Health Care Options,*

provides enrollees and potential enrollees with information on how MCMC and Dental MC works, who must enroll, how to get a medical or non-medical exemption from enrollment, what medical and dental benefits are covered, and how to choose a plan. All of this information is provided on a State website, healthcareoptions.dhcs.ca.gov. Also included on the website is quality reporting and provider directories for each participating plan. Additionally, all beneficiaries receive an annual mailing that provides information about the plan options in their county and an enrollment form through which they can select or change plans. The Health Care Options program also hosts in-person information sessions throughout the State in non-COHS counties, where prospective enrollees are presented with information about the MCMC and Dental MC (if applicable) program and help choosing a plan. DHCS also has a Health Care Options call center that is open Monday to Friday, 8 am to 6 pm, except holidays. Toll-free numbers are provided for 18 different languages as well as a TTY line. The Health Care Options program is administered by Maximus, which is under contract with DHCS to serve as Medi-Cal's enrollment broker and perform other outreach and education activities.

***SMHS**: County MHPs provide a beneficiary handbook regarding the SMHS program that includes the county's toll-free 24/7 access line, and a booklet that provides basic information about SMHS and how to access them.*

***DMC-ODS**: DMC-ODS plans provides a beneficiary handbook regarding DMC-ODS that includes the toll-free 24/7 access line, and a booklet that provides basic information about DMC-ODS services and how to access them.*

b. **Potential Enrollee Information**

Information is distributed to potential enrollees by:

___ State
__X__ contractor (please specify) **Maximus** (*Applies to MCMC, Dental MC*)

__X__ There are no potential enrollees in this program. (Check this if State automatically enrolls beneficiaries into a single PIHP or PAHP) *(Applies to SMHS, DMC-ODS)*

c. **Enrollee Information**

The State has designated the following as responsible for providing required information to enrollees:

(i) **X** the State

(ii) **X** State contractor (please specify): Information required to be provided under 42 CFR § 438.10 (f)(2)) *(Applies to MCMC and Dental MC)*

(iii) **X** the MCO/PIHP/PAHP/PCCM/FFS selective contracting provider *(Applies to SMHS, DMC-ODS)*

DHCS Response

42 CFR § 438.10(g)-(h): *DHCS requests a waiver of 42 CFR § 438.10(g)-(h), which establishes specific requirements for the types, content and distribution of information describing the SMHS and DMC-ODS programs. This allows County MHPs to provide informing materials and provider lists that meet the content requirements of § 438.10 to beneficiaries when they first access SMHS through the County MHP and on request and DMC-ODS to provide informing materials and provider lists that meet the content requirements of § 438.10 to beneficiaries when they first access SUD services through the DMC-ODS and on request. The waiver of subsections (g)-(h) would apply to the distribution requirements of the subsection only, not to any other provisions of the subsection except as directly related to the issue of distribution. CMS previously approved a waiver of this regulatory provision as 42 CFR § 438.10(f)(3) (prior to amendments made through CMS' 2016 Medicaid managed care rule) in California's SMHS Section 1915(b) waiver and Medi-Cal 2020 Section 1115 demonstration. To the extent necessary, the continuation of waivers previously granted are requested of all sections of the federal regulations that mention the obligation to inform all enrollees, to instead allow informing of all beneficiaries on request and/or when a beneficiary first accesses SMHS though a County MHP, or SUD services through DMC-ODS.*

42 CFR § 438.10(i): *DHCS requests a waiver of 42 CFR § 438.10(i), which establishes specific requirements for the types, content and distribution of information describing DMC-ODS. This allows the DMC-ODS plan to provide informing materials and provider lists that meet the content requirements of § 438.10 to beneficiaries when they first access SUD services through the DMC-ODS and on request. The waiver of subsection (i) would apply to the distribution requirements of the subsection only, not to any other provisions of the subsection except as directly related to the issue of distribution. CMS previously approved a waiver of this*

regulatory provision as 42 CFR § 438.10(f)(3) (prior to amendments made through CMS' 2016 Medicaid managed care rule) in California's Medi-Cal 2020 Section 1115 demonstration. To the extent necessary, the continuation of waivers previously granted are requested of all sections of the federal regulations that mention the obligation to inform all enrollees, to instead allow informing of all beneficiaries on request and/or when a beneficiary first accesses SUD services through DMC-ODS

C. Enrollment and Disenrollment

1. Assurances.

X The State assures CMS that it complies with section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment; in so far as these regulations are applicable.

X The State seeks a ~~waiver of a~~ waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any. (Please check this item if the State has requested a waiver of the choice of plan requirements in section A.I.C) *(Applies to SMHS, DMC-ODS)*

DHCS Response

Waivers of 42 CFR § 438.56 have been granted previously by CMS. DHCS requests that these waivers again be granted, as they have not detrimentally impacted access to or quality of care.

The text stricken out above appears to be a typographical error in the pre-print template.

X The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

___ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

2. **Details**. Please describe the State's enrollment process for MCOs/PIHPs/PAHP/PCCMs and FFS selective contracting provider by checking the applicable items below.

a. **X** **Outreach**. The State conducts outreach to inform potential enrollees, providers, and other interested parties of the managed care program. Please describe the outreach process, and specify any special efforts made to reach and provide information to special populations included in the waiver program:
(Applies to MCMC, Dental MC, SMHS, DMC-ODS)

DHCS Response

***MCMC and Dental MC**: As stated above, DHCS has a robust program in place to help enrollees and potential enrollees understand the managed care program. The program, known as Health Care Options, provides enrollees and potential enrollees with information on how MCMC and Dental MC works, who must enroll, how to get a medical or non-medical exemption from enrollment, what medical and dental benefits are covered, and how to choose a plan. All of this information is provided on a State website, healthcareoptions.dhcs.ca.gov. Also included on the website is quality reporting and provider directories for each participating plan. Additionally, all beneficiaries receive an annual mailing that provides information about the options in their county and an enrollment form through which they can select or change plans. DHCS hosts information sessions throughout the State in connection with the Health Care Options program at which State representatives explain the MCMC and Dental MC programs and help beneficiaries choose a plan. DHCS also has a Health Care Options call center that is open Monday to Friday, 8 am to 6 pm, except holidays. Toll-free numbers are provided for 18 different languages.*

***SMHS and DMC-ODS:** DHCS provides information about the SMHS and DMC-ODS programs to potential enrollees, providers, and other interested parties through the Medi-Cal website and Medi-Cal handbook, which is provided to beneficiaries upon enrollment.*

b. Administration of Enrollment Process.

X State staff conducts the enrollment process. *(Applies to SMHS, DMC-ODS)*

__X__ The State contracts with an independent contractor(s) (i.e., enrollment broker) to conduct the enrollment process and related activities. *(Applies to MCMC, Dental MC)*

__X__ The State assures CMS the enrollment broker contract meets the independence and freedom from conflict of interest requirements in section 1903(b) of the Act and 42 CFR 438.810.

Broker name: **Maximus**

Please list the functions that the contractor will perform:

__X__ choice counseling
__X__ enrollment
___ other (please describe):

___ State allows MCO/PIHP/PAHP or PCCM to enroll beneficiaries. Please describe the process.

c. Enrollment. The State has indicated which populations are mandatorily enrolled and which may enroll on a voluntary basis in Section A.I.E.

___ This is a **new** program. Please describe the **implementation schedule** (e.g. implemented statewide all at once; phased in by area; phased in by population, etc.):

__X__ This is an existing program that will be **expanded** during the renewal period. Please describe the **implementation schedule** (e.g. new population implemented statewide all at once; phased in by area; phased in by population, etc.):

DHCS Response

***MCMC**: Under CalAIM, DHCS is proposing to further standardize MCMC enrollment and require certain additional aid code groups to enroll in MCMC in all counties starting in 2022, and require all dual eligibles to enroll in MCMC in 2023. This will allow MCPs to provide more coordinated and integrated care statewide and provide beneficiaries who have been in FFS or who have not been required to enroll in an MCP with a network of primary care providers and specialists.*

***Effective January 1, 2022.** Mandatory enrollment of:*

- *Trafficking and Crime Victims Assistance Program (except share of cost);*
- *Individuals participating in accelerated enrollment;*

- *Child Health and Disability Prevention infant deeming;*
- *Pregnancy-related Medi-Cal[20] (Pregnant Individuals only, 138-213 percent FPL citizen/lawfully present);*
- *American Indians and Alaska Natives in non-COHS counties[21];*
- *Beneficiaries with other health care coverage in non-COHS counties; and*
- *Beneficiaries living in rural zip codes in non-COHS counties.*

Mandatory enrollment of these additional aid code groups will be implemented all at once.

***Effective January 1, 2023.** Mandatory enrollment of all dual and non-dual individuals eligible for long-term care services and all partial and full dual aid code groups, except share of cost or restricted scope. Mandatory enrollment of these additional aid code groups will be implemented all at once.*

X If a potential enrollee **does not select** an MCO/PIHP/PAHP or PCCM within the given time frame, the potential enrollee will be **auto-assigned** or default assigned to a plan.*(Applies to MCMC in non-COHS counties, Dental MC)*

i. **X** Potential enrollees will have **30** ***days*** ~~/month(s)~~ to choose a plan.

ii. **X** Please describe the auto-assignment process and/or algorithm. In the description please indicate the factors considered and whether or not the auto-assignment process assigns persons with special health care needs to an MCO/PIHP/PAHP/PCCM who is their current provider or who is capable of serving their particular needs.

DHCS Response

In non-COHS and non-Single Plan counties for MCMC and for Dental MC in Sacramento, DHCS uses an auto-assignment algorithm to reward plans with automatic enrollment of Medi-Cal beneficiaries based on encounter data quality and performance measures related to quality

[20] Under pending state legislation, pregnant women accessing services FFS prior to January 1, 2022, will remain in FFS through their postpartum period and not be mandatorily enrolled in MCMC.

[21] As is consistent with current policy, all American Indians and Alaska Natives residing in non-COHS counties will continue to have the ability to opt out of MCMC for FFS.

and support of safety-net providers. In assigning enrollees through the default process, DHCS does not consider the individual needs or medical and/or dental history of any particular beneficiary. However, a beneficiary who was previously enrolled in a plan or has a family member who is enrolled in a plan will be defaulted into the prior plan or family member's current plan, rather than assigned to a plan through the auto-assignment process. The State refers to this as a continuity of care default.

X The State **automatically enrolls** beneficiaries

___ on a mandatory basis into a single MCO, PIHP, or PAHP in a rural area (please also check item A.I.C.3)

X on a mandatory basis into a single PIHP or PAHP for which it has requested a waiver of the requirement of choice of plans (please also check item A.I.C.1)*(Applies to SMHS, DMC-ODS)*

X on a voluntary basis into a single MCO, PIHP, or PAHP. The State must first offer the beneficiary a choice. If the beneficiary does not choose, the State may enroll the beneficiary as long as the beneficiary can opt out at any time without cause. Please specify geographic areas where this occurs:
(Applies to MCMC in COHS counties; Updated for November 2022 amendment: applies to MCMC in Single Plan counties)

DHCS Response

***MCMC**: Under the COHS model, beneficiaries are served by a single plan that is created and administered by a county's board of supervisors, or other local health authority. These single, local plans are considered HIOs, which are managed care delivery systems unique to California and operate under the authority of § 9517(c) of COBRA 1985, which was subsequently amended by § 4734 of OBRA 1990 and MIPAA 2008. HIOs are exempt from the managed care requirements of § 1932 of the Act (implemented through 42 CFR § 438) because they are not subject to the requirements under § 1903(m)(2)(A) that apply to MCOs and contracts with MCOs. 42 CFR § 438.2 identifies these as county-operated entities and California state law that passed*

simultaneously with OBRA 1990 identifies these as COHS. The entities covered by the Section 1915(b) waivers operate under the HIO authority to deliver benefits to State plan populations; the Health Plan of San Mateo is considered a COHS, but is not considered an HIO by federal standards because it became operational after January 1, 1986. A COHS plan must enroll all Medicaid beneficiaries residing in the county in which it operates except when an alternative delivery system is authorized and available in the county.

In certain counties (Humboldt and Orange at the time of this submission), beneficiaries may be subsequently disenrolled from COHS to be enrolled in PACE, if eligible.

In 2022, dual eligible beneficiaries in CCI and COHS counties are subject to mandatory enrollment in MCMC for Medi-Cal benefits, and in non-COHS and non-CCI counties are subject to voluntary enrollment in MCMC for Medi-Cal benefits. Starting January 1, 2023, all dual eligibles except for individuals otherwise excluded from MCMC such as those with a Share of Cost not in institutional long term care and other MCMC excluded populations, will be subject to mandatory enrollment in MCMC. For dual eligible beneficiaries who opt to enroll in a Medicare Advantage plan, DHCS will align these beneficiaries' Medi-Cal MCP enrollment with their Medicare Advantage plan enrollment whenever possible to allow for greater integration and coordination of care.DHCS plans to transition to aligned enrollment in select non-COHS counties in 2022, and will expand this approach statewide in future years. California is utilizing Section 1115 expenditure authority related to the provisions in 42 CFR § 438.56 to operationalize the aligned enrollment approach for dually eligible enrollees.

DHCS Update for November 2022 Amendment

Through an amendment to the 1915(b) submitted to CMS in November 2022, DHCS is seeking to expand the existing COHS model and establish a new MCMC model known as the Single Plan.

MCMC: Under the COHS and Single Plan models, beneficiaries are served by a single plan[22] that is created and administered by a county's board of supervisors, or other local health authority. California is seeking an amendment to reflect use of the rural area exemption for rural counties in existing and expanding COHS as well as rural counties intending to operate a Single Plan. As noted above, DHCS had authority relating to the existing COHS to limit Medi-Cal managed care plan choice under federal law provisions[23] that exempt them from the otherwise applicable managed care choice requirements set forth in Section 1903(m)(2)(A) of the Social Security Act. Four of these COHS are HIOs under federal law; their statutory exemption from 1903(m)(2)(A) is conditioned on not exceeding a 16% enrollment level in those four COHS as a share of all Medi-Cal beneficiaries. Once the 16% enrollment level is exceeded, the managed care requirements in 42 CFR Part 438, including choice provisions, would apply to all HIOs currently operating under federal statute. DHCS projects that enrollment will likely be close to or exceed the aggregate 16% level following the expansion of two of those four COHS/HIOs into new counties.

Given enrollment will be close to or in excess of the aggregate 16% level following the expansion of the COHS model, DHCS is requesting an amendment to the CalAIM 1915(b) waiver to reflect use of the rural area exemption for rural counties in existing and expanding COHS as well as

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[22] In COHS and Single Plan counties where Kaiser Foundation Health Plan operates as a full-risk, full-scope Medi-Cal managed care plan, Medi-Cal members will have choice of more than one managed care plan. Under the Kaiser direct contract, if the beneficiary does not choose, the State on a voluntary basis may enroll the beneficiary when there is: family linkage, for dual eligibles (those eligible for both Medicare and Medi-Cal), foster children/youth, continuity from Kaiser's other of business (i.e. individuals leaving employer-sponsored Kaiser coverage and other payer-sponsored Kaiser coverage), and default enrollment for all Medi-Cal beneficiaries up to an annual cap per county based on projected capacity.

[23] SSA 1932(a)(3): requires choice of at least two MCOs, with specific exceptions including:

- COHS / HIOs that became operational prior to Jan 1, 1986;
- HIOs as outlined in Sec. 9517(c), if total membership in those HIOs is under 16% of Medi-Cal beneficiaries; and
- Rural areas if >2 physicians or case managers (if available in the area) and may go out-of-network in appropriate circumstances.

rural counties intending to operate a Single Plan. Through a separate submission, DHCS is also seeking an amendment to its CalAIM Section 1115 Demonstration to secure expenditure authority to limit plan choice in non-rural areas for all COHS and rural counties intending to operate a Single Plan.

___ The State provides guaranteed eligibility of ____ months (maximum of 6 months permitted) for MCO/PCCM enrollees under the State plan.

X The State allows otherwise mandated beneficiaries to request exemption from enrollment in an MCO/PIHP/PAHP/PCCM. Please describe the circumstances under which a beneficiary would be eligible for exemption from enrollment. In addition, please describe the exemption process:
(Applies to MCMC, Dental MC)

DHCS Response

***MCMC – COHS, GMC, Two-Plan, Regional, and Imperial Models; Following November 2022 Amendment, Single Plan Model**:*

22 CCR § 53887 governs medical and dental exemption requests. A beneficiary who is receiving a course of treatment for a complex medical (dental) condition that cannot be interrupted from a FFS provider may request a temporary exemption from mandatory enrollment in an MCP. A DHCS approved exemption allows the beneficiary to continue the course of treatment for the complex medical (or dental) condition with the FFS provider. DHCS is authorized to approve or deny a request for medical or dental exemption and an approval is valid for a period of up to 12 months for purposes of continuity of care.

22 CCR § 53887 prohibits DHCS from approving a request for exemption from MCP enrollment for a beneficiary who: (i) has been a member of a plan in the beneficiary's county on a combined basis for more than 90 calendar days; (ii) has a current FFS Medi-Cal provider who is also contracted with an MCP in the beneficiary's county; or (iii) began or was scheduled to begin treatment for the complex medical condition after the date of plan enrollment.

To receive a temporary medical or dental exemption, a beneficiary must submit a form titled, "Request for Temporary Medical (or Dental) Exemption from Plan Enrollment" to DHCS for a determination of whether the clinical information supports approving the exemption. The form is available on DHCS' website and upon request from the MCMC Health Care Options Program.

If the exemption is approved, the beneficiary may continue to receive care from their FFS provider for up to 12 months unless the complex medical (or dental) condition has stabilized to a point where the beneficiary can safely transition to an MCP, or in the case of pregnancy, 90 days after a beneficiary gives birth. See 22 CCR § 53887

After a beneficiary's temporary medical or dental exemption expires, they may apply for a new exemption. If a beneficiary's application for exemption is denied, the beneficiary may be seen by their FFS provider for an additional 12 months, if the provider and the MCP can agree to the continuity of care policies of the beneficiary's MCP. See California Health & Safety Code § 1373.96.

***Dental MC**:*

Pursuant to CA WIC § 14089.09(b)(2), DHCS implemented the Beneficiary Dental Exception (BDE) process for Medi-Cal members in Sacramento County who are unable to secure access to services through their dental plan, in accordance with applicable contractual timeframes and the Knox-Keene Health Service Plan Act of 1975 (Chapter 2.2 (commencing with § 1340) of Division 2 of the California Health and Safety Code). The BDE process allows DHCS staff to work with the plans on behalf of the members to facilitate the scheduling of appropriate appointments based on the identified needs of the member. If an appointment is available within the required timeframe, DHCS will work with the plan and the member to coordinate care.

If an appointment is not available within the required timeframe, the member may request to opt-out of Dental MC and move into Dental FFS delivery system where they may select their own dental provider on an ongoing basis. The member may remain in FFS until he or she chooses to opt back into Dental MC.

X *(Applies to MCMC, Dental MC)* The State automatically re-enrolls a beneficiary with the same PCCM or MCO/PIHP/PAHP if there is a loss of Medicaid eligibility of 2 months or less.

d. Disenrollment:

DHCS Response

Waivers of 42 CFR § 438.56 have been granted previously in connection with SMHS and DMC-ODS. DHCS requests that these waivers again be granted, as they have not detrimentally impact access to or quality of care

X The State allows enrollees to disenroll from/transfer between MCOs/PIHPs/PAHPs and PCCMs. Regardless of whether plan or State makes the determination, determination must be made no later than the first day of the second month following the month in which the enrollee or plan files the request. If determination is not made within this time frame, the request is deemed approved. *(Applies to MCMC in non-COHS counties, Dental MC)*

i. **X** Enrollee submits request to State.

DHCS Response

Disenrollments and plan changes are submitted to the State's enrollment broker, Maximus. Maximus processes these requests on behalf of the State.

ii.___ Enrollee submits request to MCO/PIHP/PAHP/PCCM. The entity may approve the request, or refer it to the State. The entity may not disapprove the request.

iii.___ Enrollee must seek redress through MCO/PIHP/PAHP/PCCM grievance procedure before determination will be made on disenrollment request.

X The State **does not permit disenrollment** from a single PIHP/PAHP (authority under 1902 (a)(4) authority must be requested), or from an MCO, PIHP, or PAHP in a rural area. *(Applies to MCMC in COHS counties, SMHS, DMC-ODS)*

DHCS Response

***MCMC**: In COHS counties, mandatory enrollees are restricted to a single plan. Under all other models, mandatory enrollees have a choice of plans, and in San Benito County, a choice between a single plan and FFS. Following November 2022 Amendment: In COHS and Single Plan counties, mandatory enrollees are restricted*

to a single plan.[24] Under all other models, mandatory enrollees have a choice of plans.

SMHS and DMC-ODS: *Beneficiaries receive SMHS and DMC-ODS from their county's plans, without any option for disenrollment.*

___ The State has a **lock-in** period (i.e. requires continuous enrollment with MCO/PIHP/PAHP/PCCM) of ___months (up to 12 months permitted). If so, the State assures it meets the requirements of 42 CFR 438.56(c).

Please describe the good cause reasons for which an enrollee may request disenrollment during the lock-in period (in addition to required good cause reasons of poor quality of care, lack of access to covered services, and lack of access to providers experienced in dealing with enrollee's health care needs):

DHCS Response

__X__ The State **does not have a lock-in,** and enrollees in MCOs/PIHPs/PAHPs and PCCMs are allowed to terminate or change their enrollment without cause at any time. The disenrollment/transfer is effective no later than the first day of the second month following the request. *(MCMC in non-COHS counties, Dental MC)*

__X__ The State permits MCOs/PIHPs/PAHPs and PCCMs to request disenrollment of enrollees. Please check items below that apply: *(Applies to MCMC, Dental MC)*

i. __X__ MCO/PIHP/PAHP and PCCM can request reassignment of an enrollee for the following reasons:

DHCS Response

MCMC*: Any reason determined by the state to constitute good cause as set forth in 22 CCR § 53891(a)(7).*

ii. __X__ *(Applies to MCMC, Dental MC)* The State reviews and approves all MCO/PIHP/PAHP/PCCM-initiated requests for enrollee transfers or disenrollments.

[24] In COHS and Single Plan counties where Kaiser Foundation Health Plan operates as a full-risk, full-scope Medi-Cal managed care plan, Medi-Cal members will have choice of more than one managed care plan.

iii. **X** *(Applies to MCMC, Dental MC)* If the reassignment is approved, the State notifies the enrollee in a direct and timely manner of the desire of the MCO/PIHP/PAHP/PCCM to remove the enrollee from its membership or from the PCCM's caseload.

iv. **X** *(Applies to MCMC, Dental MC)* The enrollee remains an enrollee of the MCO/PIHP/PAHP/PCCM until another MCO/PIHP/PAHP/PCCM is chosen or assigned.

D. Enrollee Rights

1. Assurances.

_X_ The State assures CMS that it complies with section 1932(a)(5)(B)(ii) of the Act and 42 CFR 438 Subpart C Enrollee Rights and Protections. *(Applies to MCMC, Dental MC, SMHS, DMC-ODS)*

_____ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

_X_ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5)(B)(ii) of the Act and 42 CFR Subpart C Enrollee Rights and Protections. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM. *(Applies to MCMC, Dental MC, SMHS, DMC-ODS)*

___ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

_X_ State assures CMS it will satisfy all HIPAA Privacy standards as contained in the HIPAA rules found at 45 CFR Parts 160 and 164. *(Applies to MCMC, Dental MC, SMHS, DMC-ODS)*

E. Grievance System

1. **Assurances for All Programs**. States, MCOs, PIHPs, PAHPs, and States in PCCM and FFS selective contracting programs are required to provide Medicaid enrollees with access to the State fair hearing process as required under 42 CFR 431 Subpart E, including:
    a. informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action,
    b. ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if State takes action without the advance notice and as required in accordance with State Policy consistent with fair hearings. The State must also inform enrollees of the procedures by which benefits can be continued for reinstated, and
    c. other requirements for fair hearings found in 42 CFR 431, Subpart E.

__X__ The State assures CMS that it complies with Federal Regulations found at 42 CFR 431 Subpart E. *(Applies to MCMC, Dental MC, SMHS, DMC-ODS)*

2. **Assurances For MCO or PIHP programs.** MCOs/PIHPs are required to have an internal grievance system that allows an enrollee or a provider on behalf of an enrollee to challenge the denial of coverage of, or payment for services as required by section 1932(b)(4) of the Act and 42 CFR 438 Subpart H.

__X__ The State assures CMS that it complies with section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System, in so far as these regulations are applicable. *(Applies to MCMC, SMHS, DMC-ODS)*

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

__X__ The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM. *(Applies to MCMC, Dental MC, SMHS, DMC-ODS)*

3. Details for MCO or PIHP programs.

a. Direct access to fair hearing.

X The State requires enrollees to exhaust the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing. *(Applies to MCMC, SMHS, DMC-ODS)*

DHCS Response

As per 42 CFR § 438.402, an enrollee may request a State fair hearing only after receiving notice that the MCO, PIHP, or PAHP is upholding the adverse benefit determination. And, if the MCO, PIHP, or PAHP fails to adhere the notice and timing requirements under 42 CFR § 438.408, the enrollee is deemed to have exhausted the MCO, PIHP, or PAHP appeals process and may initiate a State fair hearing.

___ The State does not require enrollees to exhaust the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing.

b. Timeframes

X The State's timeframe within which an enrollee, or provider on behalf of an enrollee, must file an **appeal** is **60** days (between 20 and 90). *(Applies to MCMC, SMHS, DMC-ODS)*

___ The State's timeframe within which an enrollee must file a **grievance** is ___ days.

DHCS Response

This question appears out-dated. Per 42 CFR § 438.402(c)(2)(i), a Medicaid plan enrollee may file a grievance at any time. DHCS has adopted this standard consistent with federal requirements.

c. Special Needs

X The State has special processes in place for persons with special needs. Please describe.

DHCS Response

MCPs must ensure California Children Services (CCS) members are provided information on grievances, appeals, and state fair hearing (SFH) rights and processes. CCS-eligible members enrolled in managed care are provided the same grievance, appeal,

and SFH rights as other MCP members. MCPs must have time processes for accepting and acting upon member grievances and appeals. Enrollees appealing a CCS eligibility determination must appeal to the county CCS program.

In accordance with CA WIC § 14094.13, MCPs may extend the CCS continuity of care (COC) period, at their discretion, beyond the initial 12 month period. MCPs must provide CCS eligible members with a written notification 60 days prior to the end of the 12 month COC period informing members of their right to request a COC extension and the CCS appeal process for COC limitations. MCPs must process these requests like other standard or expedited prior authorization requests according to the timeframes set by the State. If MCPs deny requests for extended COC, they must inform members of their right to further appeal these denials with the MCP and of the member's SFH rights following the appeal process as well as in cases of deemed exhaustion.

4. **Optional grievance systems for PCCM and PAHP programs.** States, at their option, may operate a PCCM and/or PAHP grievance procedure (distinct from the fair hearing process) administered by the State agency or the PCCM and/or PAHP that provides for prompt resolution of issues. These grievance procedures are strictly voluntary and may not interfere with a PCCM, or PAHP enrollee's freedom to make a request for a fair hearing or a PCCM or PAHP enrollee's direct access to a fair hearing in instances involving terminations, reductions, and suspensions of already authorized Medicaid covered services. *(Dental MC)*

_X_ The State has a grievance procedure for its ___ PCCM and/or _X_ PAHP program characterized by the following (please check any of the following optional procedures that apply to the optional PCCM/PAHP grievance procedure):

___ The grievance procedures is operated by:
- ___ the State
- ___ the State's contractor. Please identify: _____
- ___ the PCCM
- _X_ the PAHP.

_X_ Please describe the types of requests for review that can be made in the PCCM and/or PAHP grievance system (e.g. grievance, appeals)

DHCS Response

The PAHP maintains an appeals and grievance system to ensure the recipient, review, and resolution of grievances and appeals. Appeal and grievance are defined as follows:

- *Appeals: An appeal is a review by the PAHP of an adverse benefit determination.*
- *Grievances: A grievance is an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, and the member's right to dispute an extension of time proposed by the PAHP to make an authorization decision.*

X Has a committee or staff who review and resolve requests for review. Please describe if the State has any specific committee or staff composition or if this is a fiscal agent, enrollment broker, or PCCM administrator function.

DHCS Response

The committee that reviews and resolves requests for review is an PAHP Administrator function. The PAHP has a grievance and appeals committee that meets on a quarterly basis to discuss, track, and trend grievances and appeals. Grievances and appeals reviewed shall include, but not be limited to, those related to access to care, quality of care, and denial of services. Appropriate action shall be taken to remedy any problems identified. All grievances and appeals related to dental quality of care issues are immediately summited to the PAHP's dental director for action.

X Specifies a time frame from the date of action for the enrollee to file a request for review, which is: _____ (please specify for each type of request for review)

DHCS Response

- *Appeals must be filed within 60 calendar days from the date on the Notice of Action (NOA) letter to file an appeal. If the enrollee is currently receiving treatment and wishes to continue getting treatment, the enrollee must ask for a continuation of services within 10 days from the date of the postmarked NOA or before the date the PAHP says services will stop.*
- *Grievances can be filed at any time.*

X Has time frames for resolving requests for review. Specify the time period set: _____ (please specify for each type of request for review)

DHCS Response

- *Appeals: The PAHP has 30 days to provide a response. The response is communicated through a "Notice of Appeal Resolution" (NAR) letter. This letter will tell the enrollee what the PAHP has decided. If the enrollee does not get a letter within 30 days, the enrollee can ask for an Independent Medical Review (IMR) within 180 days from the date of the NAR letter, an outside reviewer that is not related to the PAHP will review the case, or request a state hearing and an administrative law judge will review the case. For the request for state hearing, the enrollee must request (by phone or writing) it no later than 120 days from the date of the NAR letter.*
- *Grievances resolution should not exceed 30 calendar days from the date of the receipt of the grievance.*

X Establishes and maintains an expedited review process for the following reasons:_____ . Specify the time frame set by the State for this process____

DHCS Response

- *Appeals: An enrollee can request expedited appeals if the enrollee is in pain or thinks waiting 30 days will harm their health or dental function. The PAHP will make a decision within 72 hours of receiving enrollee's appeal. 42 CFR § 438.408 (b) and (c) allows for a 14 calendar day extension for standard and expedited appeals.*
- *Grievances: 42 CFR § 438.408(b) and (c) allow for a 14 calendar day extension for standard and expedited appeals. This does not apply to grievances.*

X Permits enrollees to appear before State PCCM/ PAHP personnel responsible for resolving the request for review.

DHCS Response

The PAHP provides the enrollee a reasonable opportunity, in person and in writing, to present evidence and testimony. The PAHP informs the member of the limited time available for this

sufficiently in advance of the resolution timeframe for appeals as specified and in the case of expedited resolution.

X Notifies the enrollee in writing of the decision and any further opportunities for additional review, as well as the procedures available to challenge the decision.

DHCS Response

- *NOA: Formal letter informing an enrollee of an adverse benefit determination.*
- *NAR: Formal letter of the results of the resolution and date it was completed.*
- *Grievances: In the event that resolution of a standard grievance is not reached within 30 calendar days as required, the PAHP shall notify the member in writing of the status of the grievance and the estimated date of resolution in accordance with existing state regulations.*

___ Other (please explain):

F. Program Integrity

1. Assurances.

X The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.610 Prohibited Affiliations with Individuals Barred by Federal Agencies. The State assures that it prohibits an MCO, PCCM, PIHP, or PAHP from knowingly having a relationship listed below with:

(1) An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or

(2) An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above.

The prohibited relationships are:

(1) A director, officer, or partner of the MCO, PCCM, PIHP, or PAHP;

(2) A person with beneficial ownership of five percent or more of the MCO's, PCCM's, PIHP's, or PAHP's equity;

(3) A person with an employment, consulting or other arrangement with the MCO, PCCM, PIHP, or PAHP for the provision of items and services that are significant and material to the MCO's, PCCM's, PIHP's, or PAHP's obligations under its contract with the State.

(Applies to MCMC, Dental MC, SMHS, DMC-ODS)

X The State assures that it complies with section 1902(p)(2) and 42 CFR 431.55, which require section 1915(b) waiver programs to exclude entities that:

1) Could be excluded under section 1128(b)(8) of the Act as being controlled by a sanctioned individual;
2) Has a substantial contractual relationship (direct or indirect) with an individual convicted of certain crimes described in section 1128(b)(8)(B) of the Act;
3) Employs or contracts directly or indirectly with an individual or entity that is
    a. precluded from furnishing health care, utilization review, medical social services, or administrative services pursuant to section 1128 or 1128A of the Act, or
    b. b. could be exclude under 1128(b)(8) as being controlled by a sanctioned individual.

(Applies to MCMC, Dental MC, SMHS, DMC-ODS)

2. Assurances For MCO or PIHP programs

X The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.608 Program Integrity Requirements, in so far as these regulations are applicable. *(Applies to MCMC, Dental MC, SMHS, DMC-ODS)*

X State payments to an MCO or PIHP are based on data submitted by the MCO or PIHP. If so, the State assures CMS that it is in compliance with 42 CFR 438.604 Data that must be Certified, and 42 CFR 438.606 Source, Content, Timing of Certification. *(Applies to MCMC, Dental MC, SMHS, DMC-ODS)*

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

X The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(d)(1) of the Act and 42 CFR 438.604 Data that must be Certified; 438.606 Source, Content , Timing of Certification; and 438.608 Program Integrity Requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.*(Applies to MCMC, Dental MC, SMHS, DMC-ODS)*

Section B: Monitoring Plan

Per section 1915(b) of the Act and 42 CFR 431.55, states must assure that 1915(b) waiver programs do not substantially impair access to services of adequate quality where medically necessary. To assure this, states must actively monitor the major components of their waiver program described in Part I of the waiver preprint:

Program Impact	(Choice, Marketing, Enrollment/Disenrollment, Program Integrity, Information to Beneficiaries, Grievance Systems)
Access	(Timely Access, PCP/Specialist Capacity, Coordination and Continuity of Care)
Quality	(Coverage and Authorization, Provider Selection, Quality of Care)

For each of the programs authorized under this waiver, this Part identifies how the state will monitor the major areas within Program Impact, Access, and Quality. It acknowledges that a given monitoring activity may yield information about more than one component of the program. For instance, consumer surveys may provide data about timely access to services as well as measure ease of understanding of required enrollee information. As a result, this Part of the waiver preprint is arranged in two sections. The first is a chart that summarizes the activities used to monitor the major areas of the waiver. The second is a detailed description of each activity.

MCO and PIHP programs. The Medicaid Managed Care Regulations in 42 CFR Part 438 put forth clear expectations on how access and quality must be assured in capitated programs. Subpart D of the regulation lays out requirements for MCOs and PIHPs, and stipulates they be included in the contract between the state and plan. However, the regulations also make clear that the State itself must actively oversee and ensure plans comply with contract and regulatory requirements (see 42 CFR 438.66, 438.202, and 438.726). The state must have a quality strategy in which certain monitoring activities are required: network adequacy assurances, performance measures, review of MCO/PIHP QAPI programs, and annual external quality review. States may also identify additional monitoring activities they deem most appropriate for their programs.

For MCO and PIHP programs, a state must check the applicable monitoring activities in Section II below, but may attach and reference sections of their quality strategy to provide details. If the quality strategy does not provide the level of detail required below, (e.g. frequency of monitoring or responsible personnel), the state may still attach the quality strategy, but must supplement it to be sure all the required detail is provided.

PAHP programs. The Medicaid Managed Care regulations in 42 CFR 438 require

the state to establish certain access and quality standards for PAHP programs, including plan assurances on network adequacy. States are not required to have a written quality strategy for PAHP programs. However, states must still actively oversee and monitor PAHP programs (see 42 CFR 438.66 and 438.202(c)).

PCCM programs. The Medicaid Managed Care regulations in 42 CFR Part 438 establishes certain beneficiary protections for PCCM programs that correspond to the waiver areas under "Program Impact." However, generally the regulations do not stipulate access or quality standards for PCCM programs. State must assure access and quality in PCCM waiver programs, but have the flexibility to determine how to do so and which monitoring activities to use.

1915(b)(4) FFS Selective Contracting Programs: The Medicaid Managed Care Regulations do not govern fee-for-service contracts with providers. States are still required to ensure that selective contracting programs do not substantially impair access to services of adequate quality where medically necessary.

Part I: Summary Chart of Monitoring Activities

Please use the chart on the next page to summarize the activities used to monitor major areas of the waiver program. The purpose is to provide a "big picture" of the monitoring activities, and that the State has at least one activity in place to monitor each of the areas of the waiver that must be monitored.

Please note:

- **MCO, PIHP, and PAHP** programs -- there must be at least one checkmark in each column.

- **PCCM and FFS selective contracting** programs – there must be at least one checkmark in each sub-column under "Evaluation of Program Impact." There must be at least one check mark in one of the three sub-columns under "Evaluation of Access." There must be at least one check mark in one of the three sub-columns under "Evaluation of Quality."

- **If this waiver authorizes multiple programs**, the state may use a single chart for all programs or replicate the chart and fill out a separate one for each program. If using one chart for multiple programs, the state should enter the program acronyms (MCO, PIHP, etc.) in the relevant box.

DHCS Response

DHCS' 10-year vision for Medi-Cal is to implement a whole-system, person-centered, population health approach to equitable health and social care. This is an integrated "wellness" system, which aims to support and anticipate health

needs, to prevent illness, and to reduce the impact of poor health. Services and support will deliver high-quality care that is accessible and useable to achieve more equal health outcomes across the entire continuum of care, for all.

DHCS envisions transitioning to this future state via immediate recovery efforts arising out of the COVID-19 pandemic and longer-term strategy leveraging the CalAIM initiative. The COVID-19 pandemic had clear impact on health care delivery and outcomes, in addition to exacerbating underlying health care disparities. In direct response to this, DHCS' immediate quality efforts will include focused efforts to address gaps in care and eliminate longstanding health care disparities in: 1) children's preventive services, 2) integrated behavioral health and 3) maternal outcomes, particularly in the postpartum period. In parallel, the quality strategy will focus on the implementation of Population Health Management, which serves as a cornerstone of the CalAIM proposal. This cohesive plan of action for addressing member needs across the continuum of care based on data-driven risk stratification, predictive analytics, identifying gaps in care, and standardized assessment processes will allow DHCS to drive quality and equitable outcomes for all beneficiaries via a foundation of preventive care, patient-centered chronic disease management, and whole-person care for high-risk populations that address and mitigate social determinants of health. DHCS is also developing a department-wide strategy to align managed care sanctions policies across behavioral health, dental, and medical benefits, consistent with the goals and principles of mental health parity. Once the sanctions policies are established, DHCS plans to implement a new financial sanction program for any plan or county that is found to be deficient and not making progress on network adequacy standards or contract compliance, despite corrective action plans and intensive DHCS monitoring and oversight. DHCS anticipates implementing the new network adequacy sanctions policy for the 2022 certification submissions.

All of these efforts will be built upon foundational principles of data-driven improvements that address the whole person, eliminating health care disparities through community-centered collaboratives, and transparency and accountability, as reflected in the monitoring activities below.

The following reflects across the four delivery system programs that DHCS is seeking to authorize under this Section 1915(b) waiver:

- *Medi-Cal Managed Care (MCMC), which are MCOs and HIOs;*
- *Dental Managed Care (Dental MC), which are PAHPs;*
- *The Specialty Mental Health Services (SMHS) Program, which are PIHPs; and*
- *The Drug Medi-Cal Organized Delivery System (DMC-ODS), which are PIHPs.*

Table 8: Overview of Monitoring Activities

Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice	Marketing	Enroll/Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP/Specialist Capacity	Coordination/ Continuity	Coverage/ Authorization	Provider Selection	Quality of Care
a) Accreditation for Non-duplication				*MCMC, Dental MC*							*MCMC, Dental MC*	*MCMC, Dental MC*
b) Accreditation for Participation				*MCMC, Dental MC*	*MCMC, Dental MC*	*MCMC, Dental MC*	*MCMC, Dental MC*	*MCMC, Dental MC*	*MCMC, Dental MC*	*MCMC, Dental MC*	*MCMC, Dental MC*	*MCMC, Dental MC*
c) Consumer Self-Report data					*MCMC*		*MCMC, SMHS, DMC-ODS*					*MCMC, Dental MC, SMHS, DMC-ODS*
d) Data Analysis (non-claims)			*MCMC, Dental MC*			*MCMC, Dental MC, SMHS, DMC-ODS*	*See j. Network Adequacy Assurance by Plan*	*MCMC, Dental MC*	*MCMC, Dental MC*			

Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice	Marketing	Enroll/Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP/Specialist Capacity	Coordination/ Continuity	Coverage/ Authorization	Provider Selection	Quality of Care
e) Enrollee Hotlines	*MCMC, Dental MC*		*MCMC, Dental MC*									
f) Focused Studies							*MCMC*	*MCMC*				*MCMC*
g) Geographic Mapping								*MCMC, Dental MC, SMHS, DMC-ODS*				
h) Independent Assessment							*MCMC, Dental MC, SMHS, DMC-ODS*	*MCMC*	*MCMC*			
i) Measure Any Disparities by Racial or Ethnic Groups												*MCMC*

Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice	Marketing	Enroll/Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP/Specialist Capacity	Coordination/ Continuity	Coverage/ Authorization	Provider Selection	Quality of Care
j) Network Adequacy Assurance by Plan	*SMHS, DMC-ODS*					*SMHS, DMC-ODS*	*MCMC, Dental MC, SMHS, DMC-ODS*	*MCMC, Dental MC, SMHS, DMC-ODS*	*MCMC, Dental MC, SMHS, DMC-ODS*			
k) Ombudsman			*MCMC, Dental MC, SMHS, DMC-ODS*		*MCMC, Dental MC, SMHS, DMC-ODS*							
l) On-Site Review	*SMHS, DMC-ODS*		*SMHS, DMC-ODS*	*SMHS, DMC-ODS*	*MCMC, Dental MC, SMHS, DMC-ODS*	*Dental MC, SMHS, DMC-ODS*	*MCMC, Dental MC, SMHS, DMC-ODS*	*MCMC, Dental MC, SMHS, DMC-ODS*	*Dental MC SMHS, DMC-ODS*	*MCMC, Dental MC, SMHS, DMC-ODS*	*MCMC, Dental MC, SMHS, DMC-ODS*	*MCMC, Dental MC, SMHS, DMC-ODS*
m) Performance Improvement Projects					*SMHS, DMC-ODS*	*SMHS, DMC-ODS*	*SMHS, DMC-ODS*	*SMHS, DMC-ODS*	*SMHS, DMC-ODS*	*SMHS, DMC-ODS*	*SMHS, DMC-ODS*	*MCMC, Dental MC, SMHS, DMC-ODS*

Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice	Marketing	Enroll/Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP/Specialist Capacity	Coordination/ Continuity	Coverage/ Authorization	Provider Selection	Quality of Care
n) Performance Measures						*SMHS, DMC-ODS*	*MCMC, Dental MC, SMHS, DMC-ODS*		*SMHS, DMC-ODS*		*SMHS, DMC-ODS*	*MCMC, Dental MC, SMHS, DMC-ODS*
o) Periodic Comparison of # of Providers								*MCMC*				
p) Profile Utilization by Provider Caseload												
q) Provider Self-Report Data												
r) Test 24/7 PCP Availability					*SMHS, DMC-ODS*	*SMHS, DMC-ODS*	*MCMC*					
s) Utilization Review												*MCMC, SMHS, DMC-ODS*

Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice	Marketing	Enroll/Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP/Specialist Capacity	Coordination/ Continuity	Coverage/ Authorization	Provider Selection	Quality of Care
t. 1.) Other: Annual Marketing Plan		*MCMC, Dental MC*										
t. 2.) Other: Ongoing Monitoring Activities of SMHS and DMC-ODS	*SMHS, DMC-ODS*			*SMHS, DMC-ODS*	*SMHS, DMC-ODS*	*SMHS, DMC-ODS*	*SMHS, DMC-ODS*	*SMHS, DMC-ODS*	*SMHS, DMC-ODS*	*SMHS, DMC-ODS*	*SMHS, DMC-ODS*	*SMHS, DMC-ODS*

Part II: Details of Monitoring Activities

Please check each of the monitoring activities below used by the State. A number of common activities are listed below, but the State may identify any others it uses. If federal regulations require a given activity, this is indicated just after the name of the activity. If the State does not use a required activity, it must explain why.

For each activity, the state must provide the following information:

- Applicable programs (if this waiver authorizes more than one type of managed care program)
- Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor)
- Detailed description of activity
- Frequency of use
- How it yields information about the area(s) being monitored

A. Accreditation for Non-Duplication

a. **X** Accreditation for Non-duplication (i.e. if the contractor is accredited by an organization to meet certain access, structure/operation, and/or quality improvement standards, and the state determines that the organization's standards are at least as stringent as the state-specific standards required in 42 CFR 438 Subpart D, the state deems the contractor to be in compliance with the state-specific standards)

X NCQA
___ JCAHO
___ AAAHC
___ Other (please describe)

DHCS Response

Applicable programs: *MCMC and Dental MC*

Personnel responsible: *Delegated to plan (MCPs)*

Detailed description of activity: *DHCS does not currently require NCQA accreditation of its MCPs; however, many MCPs have chosen to pursue accreditation voluntarily, or because they also provide Qualified Health Plan coverage through Covered California (the State's health insurance marketplace) in which plans are required to be accredited by National Committee for Quality Assurance (NCQA), the Utilization Review Accreditation Commission (URAC), or the Accreditation Association for Ambulatory Health Care (AAAHC). As of December 2020, 17 of the 24 MCPs in the State are NCQA accredited. Dental MC plans are*

not required to be accredited by NCQA or a private independent accrediting entity; however, DHCS will require all MCPs achieve NCQA accreditation by 2026.

DHCS deems any MCP that is NCQA-accredited for credentialing in the State's annual Audits & Investigations (A&I) medical audits; in other words, NCQA-accredited MCPs are exempt from the credentialing section of the medical audit.

***Frequency of use:** The A&I medical audit occurs annually. MCPs that are accredited are reviewed by NCQA every three years.*

***How it yields information about the area(s) being monitored:** NCQA accreditation covers six categories: quality improvement, population health management, network management, utilization management, credentialing, and member experience. Accreditation by NCQA ensures that the MCP has met the similar DHCS requirements for credentialing. MCPs are deemed to have met the DHCS credentialing requirements, because the NCQA standard is considered consistent with and as stringent as the DHCS standard for credentialing. By deeming, DHCS relieves both the MCP and A&I State auditing staff of this particular section of the audit review.*

B. Accreditation for Participation

b. **X** Accreditation for Participation (i.e. as prerequisite to be Medicaid plan)

- **X** NCQA
- ___ JCAHO
- ___ AAAHC
- ___ Other (please describe)

DHCS Response

***Applicable programs**: MCMC and Dental MC*

***Personnel responsible:** Delegated to plan (MCPs)*

***Detailed description of activity:** As noted above, DHCS will require all MCPs achieve NCQA accreditation by 2026. DHCS may use NCQA findings to certify or deem that Medi-Cal MCPs meet particular State and federal Medicaid requirements, as it does with credentialing today. DHCS will review and consider additional elements of NCQA health plan accreditation standards for deeming and vet these elements with stakeholders before finalizing decisions.*

Frequency of use: *MCPs with NCQA accreditation are reviewed by NCQA every three years.*

How it yields information about the area(s) being monitored: *NCQA health plan accreditation yields information in six categories: quality improvement, population health management, network management, utilization management, credentialing, and member experience. Accreditation by NCQA will assist in streamlining DHCS monitoring and oversight of MCPs in these areas. As noted above, DHCS already utilizes NCQA accreditation to deem MCPs in one area, credentialing.*

C. Consumer Self-Report Data

c. **X** Consumer Self-Report data

- **X** CAHPS *(CAHPS 5.0 Adult Medicaid and CAHPS 5.0 Child Medicaid Health Plan Surveys with the HEDIS supplemental item set)*
- ___ State-developed survey
- ___ Disenrollment survey
- ___ Consumer/beneficiary focus groups

DHCS Response

Applicable programs*: MCMC*

Personnel responsible: *EQRO*

Detailed description of activity: *The administration of CAHPS surveys is optional under federal laws for Medicaid external quality review (EQR) activities at 42 CFR § 438.358(c)(2). This Medicaid EQR activity assesses managed care beneficiaries' satisfaction with their health care services in the areas that contribute to quality of care. The goal is to provide performance feedback that is actionable and will aid in improving overall beneficiary satisfaction and to illuminate any issues with quality of care for the State and MCPs to address. DHCS chooses to require that CAHPS surveys are periodically administered to both adult beneficiaries and parents or caretakers of child beneficiaries and contracts with an EQRO to administer and report results from:*

- *Title XIX Medicaid Managed Care Adult and Child Population (Medicaid): This is a statewide aggregated report, presenting statewide data and stratified by MCP. It includes the global and composite measures below in Table 8.*
- *Title XXI Children's Health Insurance Program population (CHIP): This is a statewide aggregated report, presenting*

statewide data, but not MCP-specific stratifications. It differs from the Title XIX Medicaid CAHPS report above in that while it includes the global and composite measures, it also includes the Children with Chronic Conditions (CCC) composite measures and items. See Table 8 for more.

Frequency of use:

- *The Title XIX Medicaid CAHPS survey and report have traditionally been conducted every three years, but beginning in 2020, the frequency increased to every two years.*
- *The Title XXI CHIP CAHPS survey and report are conducted annually.*

How it yields information about the area(s) being monitored: *The standardized data and results are used to identify relative strengths and weaknesses in performance, identify areas for improvement, and trend progress over time. Together, these assessments take into consideration beneficiary feedback and therefore contribute to monitoring efforts that lead to improved quality and provision of health care under Medi-Cal. According to CMS, "the quality of services is measured clinically, administratively, and through the use of patient experience of care surveys."[25] An overview of CAHPS results appears in the annual EQR Technical Report that is published in accordance with 42 CFR § 438.364.*

Table 9: Global and Composite Measures for Title XIX Medicaid and Title XXI CHIP CAHPS Reports. *The surveys include questions that address each listed topic within a rating/measure category. The CCC composite measures apply only to children with chronic conditions.*

Global Ratings	Composite Measures	CCC Composite Measures and Items
Rating of Health Plan	Getting Needed Care	Access to Specialized Services
Rating of All Health Care	Getting Care Quickly	Family Centered Care (FCC): Personal Doctor Who Knows Child
Rating of Personal Doctor	How Well Doctors	Coordination of Care for Children with Chronic Conditions

[25] CAHPS Survey Webpage, Centers for Medicare and Medicaid Services, at https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/CAHPS, accessed April 23, 2021.

Global Ratings	Composite Measures	CCC Composite Measures and Items
	Communicate	
Rating of Specialist Seen Most Often	Customer Service	Access to Prescription Medicines
	Shared Decision Making	FCC: Getting Needed Information

***Applicable programs**: Dental MC, SMHS, and DMC-ODS*

***Personnel responsible:** Dental MC plans, County MHPs, and DMC-ODS plans*

***Detailed description of activity:** DHCS utilizes consumer perception surveys to obtain feedback from beneficiaries regarding the care and services received from Dental MC plans operating in Sacramento and Los Angeles counties, County MHPs, and DMC-ODS plans. Surveys are provided by the Dental MC plans, County MHPs, and DMC-ODS plans to beneficiaries and parent/caregivers of children and youth who receive services from county-operated contracted providers (as applicable).*

For dental beneficiaries, the surveys are administered by SPH Analytics who report the results of the Child Dental Satisfaction Survey as part of its process for evaluating the quality of dental services provided to children enrolled in Dental MCPs plans. The survey is designed to evaluate overall consumer satisfaction with Dental MCPs and the network of contracted providers.

For SMHS and DMC-ODS beneficiaries, the survey results also inform the Substance Abuse and Mental Health Services Administration (SAMHSA) National Outcome Measures (NOMs) reporting.

***Frequency of use:** Consumer perception surveys are conducted annually using a convenience sampling method.*

***How it yields information about the area(s) being monitored:** The surveys collect descriptive information from each beneficiary and include questions about beneficiary satisfaction with services and quality of care (Dental MC, SMHS, DMC-ODS); timely access to care and providers available to beneficiaries (Dental MC, SMHS, DMC-ODS); whether the services improved the beneficiaries'*

functions across several domains (SMHS) and ability to abstain from drugs and alcohol (DMC-ODS); beneficiary engagement in treatment planning (DMC-ODS); and plans' cultural sensitivity (DMC-ODS) – all areas of DHCS monitoring.

D. Data Analysis (non-claims)

d. **X** Data Analysis (non-claims)

___ Denials of referral requests
X Disenrollment requests by enrollee *(MCMC, Dental MC)*
  X From plan *(MCMC)*
  ___ From PCP within plan
X Grievances and appeals *(MCMC, Dental MC, SMHS, DMC-ODS)*
X PCP termination rates and reasons *(MCMC)*
___ Other (please describe)

DHCS Response

***Strategy 1*: Disenrollment requests by enrollee from MCP**

***Applicable programs**: MCMC and Dental MC*

***Personnel responsible:** State staff and Health Care Options (HCO) contractor*

***Detailed description of activity:** HCO processes enrollments and disenrollments from MCPs that are requested by the beneficiary. Beneficiaries can request an enrollment and/or disenrollment by phone or by mail by mailing in the Choice Forms. For disenrollments, beneficiaries can disenroll from their MCP for various reasons. Some reasons include:*

- *Enrolled incorrectly into an MCP*
- *Problem using the HCO*
- *Other health or dental coverage*
- *Moved out of county*
- *Plan did not cover beneficiary needs*
- *Could not choose doctor beneficiary wanted*

The Ombudsman also processes disenrollments when requested by the beneficiary.

To track enrollee disenrollment requests, Customer Service Representatives (CSRs) at the HCO call center use the Customer Relationship Management (CRM) database, and the Ombudsman uses the Salesforce database and the Cisco VoIP system. These databases are used to record the number of calls, types of calls, language of the caller, caller's county, and subject of calls. So that

the State can monitor beneficiaries' disenrollment requests, HCO and the Ombudsman produce reports on all disenrollment activity (see below for frequency of reports and information yielded). HCO CSRs and the Ombudsman also work to maintain current governmental policies and procedures and any changes that may directly affect beneficiaries.

Frequency of use: *Monthly and quarterly – HCO produces and submits its Disenrollment Report monthly to DHCS for review; the Ombudsman produces its Disenrollment Report quarterly and shares it with the Advisory Group and posts it to the DHCS website, in accordance with State Senate Bill 97.*

How it yields information about the area(s) being monitored: *The HCO and Ombudsman-produced reports cover all disenrollment activity, such as the quantity of disenrollments and reasons for disenrollment. DHCS reviews the information provided to identify fluctuations and/or trends in MCMC and Dental MC disenrollments and takes action as needed.*

Strategy 2: Grievance and appeal data

Applicable programs*: MCMC, Dental MC, SMHS, DMC-ODS*

Personnel responsible: *State staff, Medi-Cal MCPs, Dental MC plans, County MHPs, and DMC-ODS plans*

Detailed description of activity: *DHCS requires Medi-Cal MCPs, Dental MC plans, County MHPs, and DMC-ODS plans to collect grievance and appeals data and submit this information to DHCS using a standardized reporting format. These reports summarize the numbers of grievances, appeals, expedited appeals, and information on whether the grievances, appeals, and expedited appeals are related to areas such as access, denial of services, change of provider, quality of care, confidentiality, or other issues. Information is also provided regarding dispositions (e.g., resolved, still pending).*

DHCS reviews the information provided and identifies specific deficiencies that would need to be addressed through local quality improvement processes, which may include data analysis, assessment, and comparison against established quality improvement goals, and design and implementation of interventions to improve performance. DHCS also works with MCPs, Dental MC plans, County MHPs, and DMC-ODS plans on corrective actions resulting from the annual on-site reviews, as well as through

focused reviews based on significant findings identified outside of regularly scheduled audits.

For SMHS and DMC-ODS, DHCS plans to integrate reporting by County MHPs and DMC-ODS plans during this waiver period, supporting an integrated oversight approach among county-operated behavioral health programs.

Frequency of use:

- *MCMC, Dental MC: Quarterly*
- *SMHS, DMC-ODS: Annually*

How it yields information about the area(s) being monitored: *Grievance and appeal data provides information on the categories, process, and disposition of concerns affecting beneficiaries, particularly in the areas of access to and quality of care. DHCS is able to use this information to identify deficiencies and trends. DHCS also reviews grievance and appeals data alongside data on out-of-network requests and State fair hearings to better understand if coordination of care and continuity of care requirements are being met by MCPs – grievance data can be used to highlight member concerns relating to coordination of care and/or continuity of care, while out-of-network requests can show the effectiveness of care coordination and State fair hearings can indicate improper denials of continuity of care or an MCP's coordination of a member's care.*

Strategy 3: Primary care provider (PCP) termination rates and reasons

Applicable programs*: MCMC*

Personnel responsible: *State staff and MCPs*

Detailed description of activity: *MCPs are required to submit quarterly Provider Network Reports and Subcontractors Reports. Among other things, the reports include all PCP terminations that occurred during the reporting period. The PCP termination data identifies whether MCPs can maintain an adequate provider network and indicate if there are significant network changes.*

MCPs must notify DHCS immediately upon discovery, within 10 days of learning of a PCP's exclusion from participation in the Medi-Cal program, or at least 60 days prior to a voluntary termination of a PCP that impacts 2,000 or more beneficiaries, or results in the MCP to no longer be compliant network adequacy. MCPs must

submit a narrative including how the MCP intends to provide services to impacted beneficiaries, the reason for PCP termination, and the identity of the receiving provider, if applicable. Additionally, MCPs may submit required documentation to help DHCS determine if the MCP's provider network is adequate to provide covered services to its members.

Frequency of use: *MCPs submit quarterly Provider Network Reports and Subcontractor Reports. MCPs must also notify DHCS when there is a PCP termination immediately upon discovery, within 10 days of learning of a PCP's exclusion from participating in the Medi-Cal program, or at least 60 days prior to the termination effective date.*

How it yields information about the area(s) being monitored: *PCP termination data identifies whether MCPs can continue to maintain compliance with network adequacy requirements. Re-certification of providers may be required when PCP terminations result in significant changes to the MCP's provider network or their members' access to care.*

E. Enrollee Hotlines Operated by State

e. **X** Enrollee Hotlines operated by State

DHCS Response

Applicable programs*: MCMC and Dental MC*

Personnel responsible: *HCO contractor*

Detailed description of activity*: Through its enrollee hotline, HCO provides information to Medi-Cal beneficiaries about MCPs. Beneficiaries can call the HCO line toll free at 1-800-430-4263 (English) Monday – Friday from 8 am – 6 pm Pacific Time for information on how Medi-Cal managed care works, who must enroll, beneficiary disenrollment requests, how to get a medical or non-medical exemption from enrollment, what medical and dental benefits are covered, how to choose an MCP, and the beneficiary's enrollment status. Oral translation is available in all languages through HCO's Language Line in accordance with 42 CFR 438.10(d)(4). HCO CSRs can also help beneficiaries complete enrollment/disenrollment over the phone.*

Frequency of use*: On a monthly basis, HCO produces an Enrollment Summary Report, a Beneficiary Information Report, and a Telephone Call Center Report for DHCS review.*

How it yields information about the area(s) being monitored: *As noted above, CSRs at the HCO call center use the CRM database for various tracking purposes. The database records the number of calls, types of calls, language of the caller, caller's county, and subject of calls, among other things. DHCS and the HCO contractor review the information to identify any trends or concerns that may lead to enhancements to the HCO enrollee hotline.*

F. Focused Studies

f. **X** Focused Studies (detailed investigations of certain aspects of clinical or non-clinical services at a point in time, to answer defined questions. Focused studies differ from performance improvement projects in that they do not require demonstrable and sustained improvement in significant aspects of clinical care and non-clinical service).

DHCS Response

Applicable programs*: MCMC*

Personnel responsible: *EQRO*

Detailed description of activity: *DHCS contracts with an EQRO to conduct focused studies in accordance with 42 CFR § 438.358(c)(5) to gain a better understanding of and identify opportunities for improving clinical and non-clinical services provided to beneficiaries. Focused study topics and lengths of studies vary. During the past several years, the EQRO has conducted focused studies on a range of topics, including a long-acting reversible contraceptive utilization; opioids and tobacco cessation; timely access to care; and health disparities in the Asian sub-population demographic.*

For each focused study, in accordance with CMS protocols, the EQRO defines the scope of work and expected objectives for the focused study topic; conducts an in-depth literature review to identify the best practices for the populations under study; and develops a study proposal encompassing the study question, study population, measurement period(s), data sources, study indicators, data collection process, and analytic plan. Each focused study may require the adaptation of standard health care quality measures for applicability to special populations; as a result, DHCS requires that the EQRO's analytic plan details the technical specification for these measures to ensure methodological soundness and reliable calculability for the populations under study.

Frequency of use: *Annually.*

How it yields information about the area(s) being monitored: *At the end of each focused study, the EQRO produces a stand-alone report in the format and with the content approved by DHCS to yield information on the area being monitored. In addition to presenting the findings associated with the study question(s), the focused study report discusses the implications of results in light of the policy environment within the State and presents actionable recommendations to improve the delivery of health care to beneficiaries. DHCS uses focused study findings to inform its approach for improving actions related to quality monitoring or performance improvement activities in partnership with the MCPs. For example, methodology development began in 2016 for the first annual Timely Access study, which appeared in the 2017-18 EQR Technical Report. This recurring study yields information on how well MCPs are providing urgent and non-urgent appointment times within the established time allowances across provider specialties. In addition to publicly publishing the results in the annual EQR Technical Report, DHCS also shares the results with the MCPs and, where applicable, mandates improvements if an MCP's performance is inadequate. Another example of the EQRO's focused studies is the Asian Sub-Population Disparity study, which found that quality of care differed among linguistic sub-populations within the larger racial/ethnic category labeled "Asian." In addition to the focused study results appearing in stand-alone reports, summaries of the results and conclusions also appear in the annual EQR Technical Report, as required by 42 CFR § 438.364.*

G. Geographic Mapping of Provider Network

g. **X** Geographic mapping of provider network

DHCS Response

Applicable programs*: MCMC and Dental MC*

Personnel responsible: *State staff, Medi-Cal MCPs, Dental MCPs*

Detailed description of activity: *DHCS' Annual Network Certification (ANC) process includes verification of MCPs and Dental MC plans' geographic allocation of network providers and compliance with time and distance standards. MCPs and Dental MC plans submit accessibility analyses and geographic access maps to demonstrate compliance. The analyses must demonstrate coverage of the MCPs and Dental MC plans entire service area(s) for current and anticipated beneficiaries for all ZIP codes by provider type.*

If an MCP or Dental MC plan is unable to comply with the time or distance

standards, the MCP or Dental MC plan must submit an alternative access standard (AAS) request to DHCS for review and approval. The MCP or Dental MC plan must prove it has exhausted all other reasonable options for contracting with providers in order to meet time and distance standards before DHCS will consider approving the AAS request. MCPs or Dental MC plans that fail to meet the ANC requirements or any other network adequacy requirements imposed by State or federal law or the plan contract may be placed under a corrective action plan and be subject to monetary sanctions.

Frequency of use: *Annual for the ANC process. As needed for AAS requests and plan ANC non-compliance.*

How it yields information about the area(s) being monitored: *Accessibility analysis and geographic access maps are used to ensure MCPs and Dental MC plans are compliant with time or distance standards, with results stratified by adult and pediatric populations and provider types including PCPs, specialty providers, hospitals, and pharmacies.*

Applicable programs: *SMHS and DMC-ODS*

Personnel responsible*: State staff, County MHPs, and DMC-ODS plans*

Detailed description of activity: *County MHPs and DMC-ODS plans must submit rendering provider locations to DHCS on an annual basis. DHCS uses geographic mapping technology to plot provider locations and transpose the locations of Medi-Cal eligible individuals per county, service type, and age group (as obtained from DHCS Medi-Cal Eligible Data System) to analyze compliance with time and distance standards. The analyses must demonstrate coverage of County MHPs and DMC-ODS entire service area(s) for current and anticipated beneficiaries for all ZIP codes by provider type. Once the analyses are complete, DHCS notifies each county of identified deficiencies,*

If a County MHP or DMC-ODS plan is unable to comply with the time or distance standards, the County MHP or DMC-ODS plan must submit an AAS request to DHCS for review and approval. The County MHP or DMC-ODS plan must prove it has exhausted all other reasonable options for contracting with providers in order to meet time and distance standards before DHCS will consider approving the AAS request. County MHPs or DMC-ODS plans that fail to meet network adequacy time and distance standards, or any other requirements imposed by State or federal law or the County MHP or DMC-ODS contract, may be placed under a corrective action plan and be subject to administrative or financial sanctions.

Frequency of use: *Annual.*

How it yields information about the area(s) being monitored: *Accessibility analysis and geographic access maps are used to ensure County MHPs and DMC-ODS plans are compliant with State time and distance standards, with results stratified by adult and pediatric populations and provider types.*

H. Independent Assessment

h. **X** Independent Assessment of program impact, access, quality, and cost-effectiveness (**Required** for first two waiver periods)

DHCS Response

Applicable programs*: MCMC, Dental MC, SMHS, DMC-ODS*

Personnel responsible: *State staff and independent assessor*

Detailed description of activity:

- *DHCS will comply with the Section 1915(b) Special Terms and Conditions requirements to: 1) arrange for independent assessments or evaluations of access to care in the Dental MC, SMHS, and DMC-ODS delivery systems, and 2) produce and publish a Medi-Cal Managed Care Plan Access Report for Multiple Lines of Business.*

I. Measurement of Any Disparities by Racial or Ethnic Groups

i. **X** Measurement of any disparities by racial or ethnic groups

DHCS Response

Applicable programs*: MCMC*

Personnel responsible: *State staff and EQRO*

Detailed description of activity:

- *Health Disparities Reports: DHCS contracts with an EQRO to conduct an annual analysis of health disparities and generate a report of their findings. The report relies on the quality measures reported by all full scope MCPs. Quality measures are stratified by demographics such as race/ethnicity and primary language to identify health disparities by certain populations.*

- *Preventive Services Report: DHCS, with assistance from its EQRO,*

develops an annual Preventive Services Report that focuses on statewide MCP-level results of pediatric health outcomes and health care utilization measures. The report stratifies by demographics such as race/ethnicity, primary language, age, gender, Medi-Cal managed care delivery type model, population density, and county. Health disparity analysis is available for each reported measure, with a particular focus on CMS Child Core Set Measures, and compared with nationwide and statewide data (when available).

- *Medi-Cal Managed Care Performance Dashboard: DHCS collects and stratifies data for race/ethnicity, primary language, and geographic region through the quarterly Medi-Cal Managed Care Performance Dashboard, housed in the CHHS Open Data Portal. The Dashboard is a comprehensive collection of data on Medi-Cal enrollment, utilization, appeals, grievances, network adequacy, and quality of care. Moving forward, DHCS plans to leverage this data and the State's ability to stratify by race/ethnicity, primary language, and other critical demographics to better identify, prevent, mitigate, and understand health disparities in Medi-Cal.*

Frequency of use: *Annually.*

How it yields information about the area(s) being monitored:

- *Health Disparities Report: The annual health disparity analysis report helps assess health disparities and provides information to the State and MCPs to address health disparities and improve health equity. The report is posted online and provides information about the differences between populations at the State level. The EQRO also produces an analysis at the MCP level that is provided to each MCP. Data provided to the MCPs must be used by the MCP in their Population Needs Assessments, and may inform other MCP quality improvement activities, including but not limited to Performance Improvement Projects. The report is also utilized by DHCS to establish strategic goals, identify opportunities to drive improvements in health equity through Medi-Cal policy, and help inform further data analysis, which may take the form of a Focus Study (see f. above).*

- *Preventive Services Report: Disparities findings from the Preventive Services Report analysis focus on children enrolled in Medi-Cal and are shared with MCPs to help deploy targeted interventions to improve outcomes in regions or in certain demographic groups where disparities have been identified.*

- *Medi-Cal Managed Care Performance Dashboard:* The quarterly

analysis will be used to identify, prevent, mitigate, and understand health disparities based on critical demographics enrolled in Medi-Cal managed care. This is part of DHCS' larger goal to address health disparities and discrimination in Medi-Cal.

J. Network Adequacy Assurance Submitted by Plan

j. **X** Network adequacy assurance submitted by plan [**Required** for MCO/PIHP/PAHP]

DHCS Response

Applicable programs: MCMC, Dental MC, SMHS, and DMC-ODS

Personnel responsible: *State staff, Medi-Cal MCPs, Dental MCPs, County MHPs, and DMC-ODS plans*

Detailed description of activity: *In accordance with 42 CFR § 438.207, DHCS certifies Medi-Cal MCPs', Dental MC plans', County MHPs', and DMC-ODS plans' provider networks to ensure compliance with State and federal standards as part of DHCS' ANC. DHCS reviews all Medi-Cal MCP, Dental MC plan, County MHP, and DMC-ODS plan network adequacy submissions to ensure they demonstrate compliance in the following areas:*

- *Time and distance standards—geographic access mapping;*
- *Network composition and capacity;*
- *Provider-to-beneficiary ratios (MCMC, SMHS, and Dental MC only);*
- *Timely access to appointments;*
- *Continuity of care;*
- *Minimum contracts with mandatory provider types; and*
- *Language assistance capabilities.*

All Medi-Cal MCPs, Dental MC plans, County MHPs, and DMC-ODS plans are required to submit enrollment and provider network data to DHCS that demonstrate that their provider networks meet the ***network adequacy standards for availability and accessibility of services****. Provider networks must also offer an appropriate range of services that is adequate for the anticipated number of beneficiaries for the service area (e.g., the county). Each Medi-Cal MCP, Dental MC plan, County MHP, and DMC-ODS plan must maintain a network of providers operating within the scope of practice under State law, that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of beneficiaries in their service area. DHCS reviews data and information from multiple sources – including network data, claims data, enrollment data, eligibility data, external quality reviews, and provider files submitted by the plans – to analyze the adequacy of each provider network.*

In addition, Medi-Cal MCPs, Dental MC plans, County MHPs and DMC-ODS plans are required to immediately notify DHCS any time there has been a significant change in their operations that would affect the adequacy and capacity of services, including (but not limited to) the composition of the provider network.

Each Medi-Cal MCP, Dental MC plan, and County MHP must also submit data that documents the ***timeliness of services*** *provided to beneficiaries. Each Medi-Cal delivery system has a specific approach to assess compliance with timely access standards and leverage the data to enable more detailed monitoring and oversight of timely access:*

- ***MCMC****: DHCS contracts with the EQRO to conduct a Timely Access Survey, the results of which are shared with DHCS for DHCS review. DHCS also shares the results of the Timely Access Survey with the MCPs on a quarterly basis and mandates improvements if an MCP's performance is determined as inadequate, per State timely access standards. DHCS also publishes a Timely Access Report annually that presents the results by MCP and shows how MCPs' performances compare with one another across the State.*

- ***Dental MC****: Dental MC plans report to DHCS compliance data and conduct phone calls on a random sample of primary and specialty dental providers within the plans' reported networks; DHCS reviews the data collected, which is then used to establish a baseline for each plan with the number of days and an average range of time it takes enrollees to access services in their county.*
    - *Initial Appointment – 4 weeks*
    - *Routine Appointment (non-emergency) – 4 weeks*
    - *Preventive Dental Care Appointment – 4 weeks*
    - *Specialist Appointment (adult) – 30 business days*
    - *Specialist Appointment (children) – 30 calendar days*
    - *Emergency Appointment – 24 hours*

  In addition, the Dental MC plans survey all primary care dentists on the average amount of time it takes for members to obtain initial appointments, routine appointments, specialist appointments, and emergency appointments. The Dental MC plans also use surveys to collect data on the number of "no show" appointments, the number of rescheduled appointments, the availability of interpreter services and an answering service, and the ratio of members to primary care dentists. DHCS collects and monitors the timely access data on a quarterly basis leading up to the ANC submission to CMS, as required by 42 CFR § 438.20.

- ***SMHS**: The timely access data collected is used to establish a baseline for County MHPs that includes, but is not limited to, the number of days and an average range of time it takes to receive an assessment and/or treatment appointment in their county. DHCS analyzes the date of a beneficiary's first request for an assessment and the first appointment date offered. For non-urgent, non-psychiatrist appointments, counties must provide an appointment within 10 business days as per CA WIC § 14197(d)(1), for 70 percent of beneficiaries.*

- *For DMC-ODS, DHCS reviews each DMC-ODS plan's policy and procedures regarding timely service to ensure compliance with timely access standards. Aligning with County MHPs (beginning FY 2022 – 2023 and continuing onward), each DMC-ODS plan will be required to submit data that documents the timeliness of services provided to Medi-Cal beneficiaries. The data will include information such as all service requests received by the DMC-ODS plan (and its network providers) during the applicable reporting period. The timely access data collected from each DMC-ODS plan will be used to establish a baseline for each DMC-ODS plan that includes the number of days and an average range of time it takes to receive an assessment and/or treatment appointment in their county.*

  To analyze the adequacy of each provider network, DHCS reviews State, Medi-Cal MCP, Dental MC plan, County MHP, and DMC-ODS plan-level data and information including network data, claims data, enrollment data, eligibility data, external quality review findings, and provider files submitted by the delivery systems' plans.

  As previously noted, Medi-Cal MCPs, Dental MC plans, County MHPs, and DMC-ODS plans that fail to meet ANC requirements will be placed under an ANC corrective action plan. As part of the corrective action plan process, Medi-Cal MCPs, Dental MC plans, and County MHPs must submit a plan of action detailing the steps they will take to remedy deficiency findings. Compliance requirements depend on the conditions of the corrective action plan and the specific delivery system – for example, Medi-Cal MCPs generally have six months to correct all deficiencies and meet compliance prior to DHCS closing the corrective action plan. DHCS also has authority to impose monetary sanctions for failure to comply with network adequacy requirements.

***Frequency of use:** Each Medi-Cal MCP, Dental MC plan, County MHP, and DMC-ODS plan submits documentation assuring adequate capacity and services on an annual basis, in accordance with § 438.207(c).*

How it yields information about the area(s) being monitored: *The information described above allows DHCS to assure plans meet federal and State requirements of maintaining an adequate network to serve beneficiaries. This includes, but is not limited to, ensuring the required provider-to-beneficiary ratios, access to providers within applicable time and distance standards, and access to appointments within timely access standards. The assurance further allows DHCS to confirm that plans that are not compliant with ANC requirements are still able to coordinate and arrange for services for beneficiaries while remedying deficiencies through the corrective action plan process.*

DHCS submits its Assurance of Compliance to CMS on an annual basis as required by 42 CFR § 438.207(d) and posts the report, once approved by CMS, on DHCS' Network Adequacy webpage.

K. Ombudsman

k. **X** Ombudsman

DHCS Response

Applicable programs: *MCMC, Dental MC, SMHS, and DMC-ODS*

Personnel responsible: *State staff*

Detailed description of the activity: *The purpose of the Ombudsman is to help solve problems from an independent and neutral standpoint to ensure that beneficiaries receive all medically necessary covered services for which Medi-Cal MCPs, Dental MC plans, County MHPs, and DMC-ODS plans are contractually responsible.*

The Ombudsman:

- *Serves as an objective resource to resolve issues between Medi-Cal managed care beneficiaries and Medi-Cal MCPs, Dental MC plans, County MHPs, and DMC-ODS plans.*
- *Helps beneficiaries with urgent enrollment and disenrollment problems.*
- *Offers information and referrals.*
- *Identifies ways to improve the effectiveness of the Medi-Cal managed care program.*
- *Educates beneficiaries on how to effectively navigate through the Medi-Cal managed care system.*
- *Connects beneficiaries with the right person/department to help them resolve a problem.*

- *Connects beneficiaries with local resources in their county who can help.*
- *Connects beneficiaries with patients' rights services.*

Beneficiaries are able to contact the office 24 hours a day, 7 days a week by email. Ombudsman staff are available Monday – Friday from 8 am to 5 pm Pacific Time, excluding holidays.

Frequency of use: *The Ombudsman produces the Senate Bill 97 Report quarterly, which includes all beneficiary calls received by the Ombudsman. These reports include the number of contacts received by phone and email, the average time for the Ombudsman to answer, the number and rate of calls abandoned, the results of the contacts including the destination of the referred calls, the number of calls referred to another entity, and demographic information.*

How it yields information about the area(s) being monitored: *The Ombudsman utilizes the Salesforce and Cisco VoIP system database for tracking purposes. This database is used to record and produce reports on the numbers of calls, type of calls, language of the caller, caller's county, and subject area of calls. Ombudsman staff capture enrollment/disenrollment transactions via Salesforce to document the reason for each transaction. DHCS reviews the information provided to identify fluctuations and/or trends in Medi-Cal Managed Care enrollment/disenrollment.*

L. On-Site Review

l. **X** On-site review

DHCS Response

***Plan Oversight Reviews* (also known as annual medical audits and triennial reviews)**

To determine compliance with DHCS contract requirements as well as applicable State and federal laws and regulations, DHCS conducts regular oversight reviews of Medi-Cal MCPs, Dental MC plans, County MHPs, and DMC-ODS plans. Historically, these oversight reviews have occurred on-site. However, with advances in technology and the COVID-19 pandemic, DHCS has been able to conduct these oversight reviews virtually in an effective manner. Ongoing, DHCS will leverage a combination of on-site and virtual modalities to conduct oversight reviews.

Applicable programs*: MCMC, Dental MC, SMHS, DMC-ODS*

Personnel responsible: *State staff*

Detailed description of activity: *DHCS conducts annual oversight reviews, known as "**annual medical audits**" of MCMC MCPs and Dental MC plans in accordance with CA WIC § 14456. Medical audits evaluate MCPs' compliance with DHCS contract requirements and applicable State and federal laws, regulations and guidelines. The audit scope encompasses six categories including:*

- *Utilization management;*
- *Case management and coordination of care;*
- *Access and availability;*
- *Member rights;*
- *Quality improvement; and*
- *Administrative and organizational capacity.*

The annual medical audit generates a report that summarizes the findings of the compliance review. MCPs may be placed on a corrective action plan for each deficiency that is found to be out of compliance. The MCP must respond to the corrective action plan by proposing a corrective action and/or documentation of the implementation of the corrective action. State staff review CAPs and provide technical assistance to the MCP, as needed, until the deficiencies are resolved. As noted, through 2020 and 2021, DHCS has successfully conducted annual medical audits virtually and may continue to do so, where applicable and appropriate, in the coming years.

*DHCS also conducts **triennial oversight reviews** onsite or virtually of each County MHP and DMC-ODS plan to determine compliance with federal and State regulations as well as the terms of the MHP and DMC-ODS plan contract. At the conclusion of the triennial review, DHCS identifies strength-based practices of the County MHP and DMC-ODS plan and provides feedback on areas of noncompliance. DHCS provides the County MHP and DMC-ODS plan with a written report of findings, which includes a description of each finding, a description of any corrective actions needed, and timeframes required for the SHMS MHP and DMC-ODS plan to come into compliance. Using a collaborative and educational approach, DHCS provides guidance and technical assistance if it determines that the MHP or DMC-ODS plan is out of compliance.*

Frequency of use: *Annual for MCMC and Dental MC; at least every three years for SMHS and DMC-ODS.*

How it yields information about the area(s) being monitored: *Oversight reviews provide DHCS with valuable information needed to evaluate plan performance on access and availability, utilization management, case management and coordination of care, quality improvement, member rights, and administrative and organizational*

capacity. These audits help DHCS determine plan compliance with requirements, and the corrective action plan process allows DHCS to monitor the progress with corrective actions, to ensure that compliance in the future.

Site Reviews

***Applicable programs**: MCMC*

***Personnel responsible:** Delegated to Medi-Cal MCPs*

***Detailed description of activity:** State law requires MCPs to ensure adequate facilities and service site locations are available to meet contractual requirements for the delivery of primary care within their service areas. All primary care provider sites must have the capacity to support the safe and effective provision of primary care services. To ensure compliance, MCPs are required to perform initial and subsequent site reviews, consisting of a Facility Site Review and a Medical Record Review, using the DHCS tools and standards.*

DHCS oversees and monitors the MCP implementation of the site review policy. Monitoring may include, but is not limited to: DHCS-conducted site reviews; oversight of the MCP methods for monitoring provider sites between periodic site reviews; and verification of appropriate use of the reviewers within their legal scope of practice, the standards outlined in this policy, and local collaborative processes. Monitoring methods may also include observing site reviewer training and certification processes, assessing data collection methods, and evaluating aggregate reports.

***Frequency of use:** At least every three years*

***How it yields information about the area(s) being monitored:** This activity helps DHCS and the MCPs ensure network providers are meeting regulatory and contractual requirements – including requirements regarding safe and complete provision of care and the provision of preventive services to beneficiaries – which informs DHCS and the MCPs on the quality of care being delivered to beneficiaries. When providers are not performing adequately, they are placed under a corrective action plan and are required to make necessary changes to their practice to ensure the deficiencies are corrected. This helps ensure that MCMC beneficiaries are offered the same, high-level quality of care – for example, in line with preventive services recommendations based on national standards, such as the American Academy of Pediatrics, United States Preventive Services Task Force, and American College of Obstetricians and Gynecologists.*

M. Performance Improvement Projects

m. **X** Performance Improvement projects [**Required** for MCO/PIHP]
X Clinical *(MCMC, SMHS, DMC-ODS)*
X Non-clinical *(Dental MC, SMHS, DMC-ODS)*

DHCS Response

***Applicable programs**: MCMC*

***Personnel responsible:** State staff, MCPs, and EQRO*

***Detailed description of activity:** Per 42 CFR § 438.330(b)(1) and (d)(1-4), all MCPs, as a part of their ongoing comprehensive quality assessment and performance improvement program, are required to conduct Performance Improvement Projects. Per DHCS' contracts with its MCPs, each MCP is required to conduct or participate in two annual PIPs. The PIPs are detailed quality improvement (QI) projects that utilize a rapid cycle Plan-Do-Study-Act (PDSA) methodology to test and adapt interventions to foster QI change. DHCS' EQRO monitors each MCP's PIPs, which are submitted in modules. An MCP is required to pass each module before progressing to the next module. Once the PIP is concluded, the EQRO validates the results of the PIP by assessing the validity and reliability of the MCPs' PIP results based on CMS' validation protocols. The annual technical report can be found on the DHCS Medi-Cal Managed Care Quality Improvement Reports webpage.*

***Frequency of use:** Ongoing—each MCP is required to conduct two PIPs at all times; each PIP lasts approximately 18 months.*

***How it yields information about the area(s) being monitored:** The rigorous process of conducting the PIPs, similar to other QI activities, can yield information on quality of care and access to care by testing and adapting interventions to address quality and access issues, so that they reach optimal impact. When an MCP finds a successful intervention through this process, they expand the intervention to other areas of their operation, as feasible, leading to greater quality and access to care. The QI process required by the PIPs can also uncover disparities in the access, provision, and/or receipt of health care. The PIPs, like other QI activities, help drive improvement through targeted provider and beneficiary specific interventions.*

***Applicable programs**: Dental MC*

***Personnel responsible:** Delegated to Dental MCPs and EQRO*

Detailed description of activity: *Through the Dental MC contract, MCPs are required to participate in two annual Quality Improvement Projects (QIPs), a "Statewide Collaborative QIP" and an "Individual QIP" (PIP). For the "Statewide Collaborative QIP," DHCS designates the topic of review, choosing a key area for all Dental Medi-Cal MCPs to focus on. In January 2018, DHCS issued APL 18-002, establishing the goal of the Statewide Collaborative QIP. Consistent with the objective of Domain 1 of the Dental Transformation Initiative (DTI), the Statewide Collaborative QIP aims to increase the annual percentage of preventive services utilization of children ages 1-20 by 10 percent over a five-year period.*

For the "Individual QIP" (PIP), the MCPs have the discretion to focus on any area identified by the MCP as in need of improvement. The EQRO is tasked with producing the annual technical report in compliance with Title 42, 42 CFR § 438.464 and 457.1250. The annual technical report can be found on the DHCS website here.

Frequency of use: *Annually, Dental MCPs submit two reports: (1) intervention progress report to the EQRO for the "Statewide Collaborative QIP" and (2) QIP submission to DHCS.*

How it yields information about the area(s) being monitored: *DHCS requires the Dental MCPs to conduct their PIP using the EQRO's rapid-cycle PIP process, which can yield information on quality of care and access to care. The QI process required by the PIP can also uncover disparities in the access, provision, or receipt of health care. The PIP activities can help drive improvement through targeted provider and beneficiary specific interventions.*

Applicable programs*: SMHS and DMC-ODS*

Personnel responsible: *State staff, County MHPs, DMC-ODS plans, and EQRO*

Detailed description of activity: *Pursuant to federal and State regulations, County MHPs and DMC-ODS plans are required to conduct two annual PIPs – one clinical and one non-clinical – focused on improving specific administrative and clinical performance in order to improve access to and quality of SMHS and DMC-ODS services.*

The EQRO conducts external quality reviews of County MHPs and DMC-ODS plans and evaluates and collects information regarding the PIPs. The EQRO summarizes its findings in individual County MHP and DMC-ODS plan reports, quarterly PIP reports, and annual aggregate summary reports. The reports can be found on CalEQRO's website here.

Frequency of use: *Ongoing; each MHP and DMC-ODS plan is required to conduct two PIPs at all times. Each PIP lasts approximately 12 months.*

How it yields information about the area(s) being monitored: *PIPs provide information to County MHPs and DMC-ODS plans that assist them to continue to make program enhancements and improve the coordination, quality, effectiveness, and/or service efficiency. The ultimate goal of a PIP is to drive continuous quality improvement activities.*

N. Performance Measures

n. **X** Performance measures [**Required** for MCO/PIHP]

- _____ Process
- **X** Health status/outcomes *(MCMC, SMHS, DMC-ODS)*
- **X** Access/availability of care *(MCMC, SMHS, DMC-ODS)*
- **X** Use of services/utilization *(MCMC, SMHS, DMC-ODS)*
- _____ Health plan stability/financial/cost of care
- _____ Health plan/provider characteristics
- **X** Beneficiary characteristics *(SMHS, DMC-ODS)*

DHCS Response

Applicable programs*: MCMC*

Personnel responsible: *State staff, Medi-Cal MCPs, and EQRO*

Detailed description of activity: *In accordance with 42 CFR § 438.330, all Medi-Cal MCPs, as a part of their ongoing comprehensive quality assessment and performance improvement program, are required to participate in the collection and submission of performance measurement data. Full scope MCPs must report annually on a series of quality metrics known as the Managed Care Accountability Set (MCAS). Measures on the MCAS are all derived from the CMS Adult and Child Core Sets and include preventive care measures, access to care measures, measures of chronic disease management, and behavioral health measures for adults, pregnant women, and infants and children.*

DHCS establishes thresholds or benchmarks for certain MCAS measures that MCPs are required to meet (the Minimum Performance Level or MPL). If MCPs do not meet the MPL of a required measure, the MCPs may be subject to required quality improvement work, financial sanctions, and/or corrective action plans with increased monitoring.

As required by 42 CFR § 438.358, 438.364, and 457.1250, DHCS contracts with an EQRO to conduct an independent assessment of the Medi-Cal program and to prepare an annual technical report. As described

in the CFR, the independent report must summarize findings on access and quality of care for the Medicaid and CHIP populations, including a description of the manner in which the data from all activities conducted in accordance with 42 CFR § 438.358 were aggregated and analyzed, and conclusions were drawn as to the quality and timeliness of and access to the care furnished by the MCP. The EQRO's independent assessment covers the calculation and validation of performance measures for Medi-Cal MCPs.

Frequency of use: *Annual.*

How it yields information about the area(s) being monitored: *The performance measures are reported annually to DHCS via the EQRO, which audits and validates MCPs' performance measurement rates. The performance measure rates provide a record of how each MCP performs compared to the national benchmarks as well as to one another, and helps DHCS and the MCPs identify priorities for intervention and action. Performance on health outcome or process measures provides a picture of the overall quality of care provided by the MCP. If MCPs fail to meet DHCS' performance standards (the MPL), DHCS may require quality improvement activities, financial sanctions, and/or corrective action plans. Overall, the results provide DHCS with valuable information on the quality, access, and timeliness of care provided to beneficiaries at both the MCP and county levels. The EQRO's annual technical report can be found on the DHCS website here.*

Applicable programs: *Dental MC*

Personnel responsible: *State staff, Dental MCPs, and EQR*

Detailed description of activity: *DHCS maintains ongoing oversight of Dental MC plans' utilization through the monitoring of the following 13 performance measures:*

- *Annual Dental Visit*
- *Use of Preventive Services*
- *Use of Sealants*
- *Count of Sealants*
- *Count of Fluoride Varnishes*
- *Use of Diagnostic Services*
- *Treatment/Prevention of Caries*
- *Exams/Oral Health Evaluations*
- *Use of Dental Treatment Services*
- *Preventive Services to Fillings*
- *Overall Utilization of Dental Services (one year, two years, three years)*
- *Continuity of Care*

- *Usual Source of Care*

DHCS uses Healthcare Effectiveness Data and Information Set (HEDIS)-like criteria to calculate performance measure utilization for Dental MC plans. DHCS uses Current Dental Terminology codes, which includes dental-specific procedure codes, to accurately capture Dental MC utilization.

DHCS retrieves encounter data from the MIS/DSS data warehouse to calculate Dental MC utilization for each of the 13 performance measures above. DHCS also validates the encounter data from the plans on a quarterly basis by cross-referencing it with the plans' self-reported performance measure reports.

Pursuant to CA WIC § 14459.6, the utilization performance measures are available for public review on a quarterly basis on DHCS' website here.

To address areas where quality improvement is required, DHCS implements: 1) payment withholds linked to submission of timely deliverables (3 percent withhold); 2) annual targeted audits conducted by DHCS related to utilization management, access and availability, member rights, and quality improvement; 3) annual audits conducted by the Department of Managed Health Care for compliance with the Knox-Keene Health Care Services Plan Act and Dental Managed Care contracting requirements; 4) Corrective Action Plans (CAPs) used to address identified deficiencies identified during the audits as needed; 5) public reporting on complaints and grievances and Quality Improvement Projects to be completed by each Dental Managed Care plan twice per year.

In the event Dental Managed Care extends beyond December 31, 2022, [i.e., the duration outlined in Assembly Bill 133 (Chapter 143, Statues of 2021; codified at Welfare and Institutions Code §14087.46(k))], DHCS commits to:

- *Finalizing approval for and applying contractual performance withholds under 42 CFR §438.6(b)(3);*
- *Conducting full-scope audits every three years, in addition to the annual targeted audits, across utilization management, case management and coordination of care, access and availability, member rights, quality improvement, and administrative and organizational capacity, with Corrective Action Plans to address identified deficiencies as needed;*
- *Identifying new performance measures and targets that will have the greatest impact on outcomes for beneficiaries and increasing public reporting of measures; and*
- *Incorporating in future contracts stronger outcomes measure targets aimed at driving parity between the quality of dental care*

offered in fee-for-services and managed care, with Corrective Action Plans implemented for plans that fail to meet the prescribed targets.

Frequency of use: *Annual.*

How it yields information about the area(s) being monitored: *The performance measures are reported annually to DHCS via its EQRO, which audits and validates the plans' performance measurement rates. The results provide DHCS information about the quality, access, and timeliness of care provided to beneficiaries at the Dental MC plan and county-level. This helps DHCS and Dental MC plans identify priorities for intervention and action.*

Applicable programs: *SMHS*

Personnel responsible: *State staff, County MHPs, and EQRO*

Detailed description of activity: *As described in DHCS' Medi-Cal Managed Care Quality Strategy, available here, DHCS conducts statewide continuous quality improvement efforts to improve the quality and performance of the SMHS program; these efforts include monitoring and oversight of County MHPs' performance and quality improvement activities.*

DHCS is working on revising and submitting its 2020 Quality Strategy to CMS. CMS has previously reviewed and provided feedback on DHCS's previous draft from November 2019 which was posted for public comment here. Given the significant impact of the COVID-19 pandemic, DHCS is significantly revising its quality strategy and aims to solicit additional public feedback in November of 2021 before submitting to CMS. An updated link will be provided to CMS once the review Quality Strategy draft is released.

The Performance Outcomes System (POS) and the SMHS Section 1915(b) waiver Special Terms and Conditions (STCs) (2015 – 2021) both require DHCS to develop SMHS performance reports and dashboards. In developing these reports and dashboards, DHCS has greatly strengthened its quality measures and reporting methodologies, which serve as a strong foundation upon which DHCS will continue to improve its SMHS quality assessment and performance improvement program.

The quality improvement goals and priorities for SMHS include:

- *Providing high-quality and accessible SMHS; and*
- *Improving coordination of care within DHCS' service delivery systems as well as other service systems the SMHS beneficiaries commonly access.*

The seven domains of DHCS' quality measurement and reporting program for SMHS include:

- *Access;*
- *Engagement;*
- *Service Appropriateness to Need;*
- *Service Effectiveness;*
- *Linkages;*
- *Cost Effectiveness; and*
- *Satisfaction.*

DHCS publishes statewide population reports based on county sizes (small rural, small, medium, large, very large) and county-level reports (formerly known as the POS) to the SMHS Performance Dashboard.

In addition, pursuant to the SMHS Section 1915(b) waiver STCs, DHCS has developed and published an SMHS Performance Dashboard for each MHP, which must be published on both the State's and County MHPs' websites in a manner that is easily accessible by the public. The SMHS Performance Dashboards must include MHP performance in the following areas: quality, access, timeliness, and translation/interpretation capabilities. Archived Statewide Aggregate SMHS Performance Dashboards and the County-Level SMHS Performance Dashboards are accessible on the DHCS website here. The SMHS Performance Dashboards for 2019 and beyond are accessible on the CHHS Open Data Portal here.

Benchmarks and performance targets for SMHS are evolving areas and DHCS will continue its efforts to determine appropriate benchmarks and performance targets for County MHPs.

***Frequency of use:** Annual.*

***How it yields information about the area(s) being monitored:** The reports described above include data on the demographics for four populations (Adult, Children/Youth, Children/Youth with an Open Child Welfare Case, Children/Youth in Foster Care) by age, gender, and race/ethnicity. Penetration information is provided for each population served and not served. The importance of including demographic information is to help better understand each population receiving SMHS program services. Utilization of services reports are shown in terms of dollars, as well as by service in time increments. This information helps identify which services are being utilized most over time and those that are not. The snapshot data show mental health service utilization by group, providing a view of each population in the system as of a certain point in time. Data on step-down services (i.e., time to next contact after an*

inpatient discharge) are also made available to help the State better identify issues with timeliness.

***Applicable programs**: DMC-ODS*

***Personnel responsible:** State staff and DMC-ODS plans*

***Detailed description of activity:** Using Section 1115 demonstration authority, DHCS implemented DMC-ODS plans through counties that opted in to develop and implement DMC-ODS services between 2015 and 2021. As of May 2021, there are 37 counties providing DMC-ODS services in various stages of implementation from the early adopters that have been providing services for three years to the more recent counties that began implementation in July 2020.*

As described in DHCS' Medi-Cal Managed Care Quality Strategy, posted here, DHCS will be developing performance measures for DMC-ODS services based on the findings from the EQRO review process, UCLA evaluation findings, and the DHCS DMC-ODS reviews and oversight activities as described elsewhere in this document.

The quality improvement goals and priorities for DMC-ODS are to provide high-quality and accessible DMC-ODS services and improve coordination of care within DHCS' service delivery systems as well as other service systems the DMC-ODS beneficiaries commonly access.

***Frequency of use:** Annual.*

***How it yields information about the area(s) being monitored:** The collection and review of performance measures will help determine the effectiveness of the DMC-ODS program while assisting the State and stakeholders with identification of gaps in services, disparities, and quality issues. The DHCS quality measures for the DMC-ODS are intended to measure whether organized SUD care increases the success of DMC-ODS beneficiaries while decreasing other system health care costs.*

O. Periodic Comparison of Number and Types of Medicaid Providers Before and After Waiver

o. **X** Periodic comparison of number and types of Medicaid providers before and after waiver

DHCS Response

***Applicable programs**: MCMC*

Personnel responsible: *State staff and Medi-Cal MCPs*

Detailed description of activity: *DHCS captures the number and types of MCMC providers through various reporting mechanisms, among them:*

- *The ANC process, which reviews the number of Medi-Cal providers (primary care physicians and specialists) in each MCP's network to identify provider-to-member ratios, and the number and types of providers available in each MCP's service area(s) to determine compliance with time and distance standards;*
- *Network Provider Templates submitted by MCPs to DHCS on a quarterly basis outlining new contracts, as well as contract terminations that occurred during the reporting period;*
- *Monthly data submitted by MCPs through the 274 File on the number and types of Medi-Cal providers, including but not limited to primary care, specialty care, facilities, vision care, mental health, and ancillary providers; and*
- *Monthly data checks by DHCS to analyze MCP compliance with provider reporting requirements.*

Frequency of use: *Monthly, Quarterly, and Annually.*

How it yields information about the area(s) being monitored: *During the ANC, DHCS evaluates the MCPs' networks to ensure that MCPs have the sufficient number of providers to meet provider-to-member ratios and are able to meet time and distance standards. As described in greater detail elsewhere in this document, MCPs that are non-compliant with either of these components (provider-to-member ratios and time and distance standards) are placed under a CAP until the MCP has rectified the deficiency(ies). Further, DHCS performs quality checks on MCPs' monthly 274 File submissions to ensure that provider information is entered correctly, and provides technical assistance when errors are identified.*

P. Profile Utilization by Provider Caseload

p. ____ Profile utilization by provider caseload (looking for outliers)

Q. Provider Self-Report Data

q. ____ Provider self-report data
___ Survey of providers
___ Focus groups

R. Test 24 Hours/7 Days a Week PCP Availability

r. **X** Test 24 hours/7 days a week PCP availability

DHCS Response

***Applicable programs**: MCMC*

***Personnel responsible:** Medi-Cal MCPs*

***Detailed description of activity:** DHCS requires MCPs to monitor 24/7 plan physician availability through the Medi-Cal managed care contracts. MCPs must have a plan or contracting physician available to coordinate the transfer of care of a beneficiary whose emergency condition is stabilized, to authorize medically necessary post-stabilization services, and for general communication with emergency room personnel. MCPs must submit to DHCS policies and procedures related to these requirements and are subject to a medical audit, in the event it is required.*

***Frequency of use:** MCPs submit policies and procedures upon becoming a Medi-Cal MCP and when edits have been made.*

***How it yields information about the area(s) being monitored:** This activity provides information about adherence to contract requirements and MCP policy and procedures related to access to care. MCPs must have approved timely access policies and procedures and must monitor network providers' compliance with access requirements. DHCS auditors may review policy and procedures and call transcripts or recordings to ensure lines are operational. Auditors may also review complaints for call lines if beneficiaries are not receiving timely access to appointments or care. Auditors may also call physician line to ensure availability.*

***Applicable programs**: SMHS and DMC-ODS*

***Personnel responsible:** DHCS, County MHPs, and DMC-ODS plans*

***Detailed description of activity:** County MHPs conduct test calls to test the 24/7 access line and submit test call results to DHCS quarterly. DHCS reviews and analyzes the results and provides technical assistance during monthly individual county calls, as needed. DHCS also conducts test calls to test the 24/7 access line before each triennial review. DHCS intends to extend this requirement to DMC-ODS plans.*

***Frequency of use:** Ongoing—monthly, quarterly, annually, and triennially.*

***How it yields information about the area(s) being monitored:** If the County MHP or DMC-ODS plan is found to be partially or totally out of compliance based on the test call, the County MHP or DMC-ODS plan will be required to submit a corrective action plan, and DHCS will monitor the*

progress of corrective action plan implementation and resolution.

S. Utilization Review

s. **X** Utilization review (e.g. ER, non-authorized specialist requests)

DHCS Response

***Applicable programs**: MCMC*

***Personnel responsible:** EQRO*

***Detailed description of activity:** On an annual basis, DHCS, with assistance from the EQRO, undertakes extensive analysis of children's utilization of preventive care services in MCMC. Utilization rates for pediatric preventive care are analyzed in the DHCS- and EQRO-developed Preventive Services Report, which focuses on statewide MCMC MCP-level results of pediatric health outcomes and health care utilization measures. This effort is in addition to tracking health care utilization through the established set of measures for MCMC MCPs through MCAS. Utilization data is analyzed by measure, age, and various demographic factors, with the goal of identifying patterns of health disparities and underutilization of preventive care services.*

***Frequency of use:** Annually.*

***How it yields information about the area(s) being monitored:** The findings from the Preventive Services Report help inform MCP actions for the upcoming year as it relates to performance improvement actions, provider engagement, and other steps that either the MCP or DHCS can leverage to help drive improvement in utilization of preventive care services among pediatric populations.*

***Applicable programs:** SMHS and DMC-ODS*

***Personnel responsible:** EQRO*

***Detailed description of activity:** DHCS contracts with an EQRO to perform extensive analysis of children's and adults' utilization of behavioral health services provided under the SMHS and the DMC-ODS programs. Utilization rates for behavioral health care are analyzed in separate County MHP and DMC-ODS county reports as well as in an Annual Statewide Technical Report. Utilization data is analyzed by performance measure, age, and various demographic factors with the goal of identifying patterns of behavioral health disparities and underutilization of behavioral health care services.*

Frequency of use: *Annually.*

How it yields information about the area(s) being monitored: *The findings from the individual County MHP/DMC-ODS county reports and the Annual Statewide Technical Report help inform County MHP and DMC-ODS county actions for the upcoming year as it relates to performance improvement actions, provider engagement, and other steps that the County MHPs, DMC-ODS counties, or DHCS can leverage to help drive improvement in utilization of behavioral health care services.*

T. Other

t. X Other: (please describe)

DHCS Response

1. ***Annual Marketing Plan***

Applicable programs*: MCMC and Dental MC*

Personnel responsible: *State staff*

Detailed description of activity: *DHCS conducts an annual review of the detailed marketing plans submitted by each MCMC MCP and Dental MC plan. DHCS also conducts recurring reviews of submissions for events and materials to ensure items meet contract requirements and adhere to the State-approved marketing plan. Items subject to State review include:*

- *Member evidence of coverage;*
- *Provider directory (including personalized provider directory, if applicable to county);*
- *Marketing events;*
- *MCP-developed programs (i.e., well-baby, well-woman, asthma control); and*
- *DHCS-developed programs and services (i.e., Pediatric Palliative Care, Health Homes).*

Frequency of use: *Ongoing – annually for State review of the MCP marketing plans; daily (as needed) for State review of marketing event and material submission.*

How it yields information about the area(s) being monitored: *The State's review of MCPs' marketing-related materials helps ensure adherence to approved marketing plans, overall accuracy, and*

compliance with State and federal requirements (e.g., requirements enumerated in 42 CFR § 438.10) and contract requirements.

2. ***Ongoing Monitoring Activities***

Applicable programs*: MCMC, SMHS, DMC-ODS*

Personnel responsible: *DHCS, MC MCPs, County MHPs, and DMC-ODS plans, EQRO*

Detailed description of activity: *DHCS conducts ongoing monitoring of County MHPs and DMC-ODS plans' compliance through:*

- ***Tiered Review Approach.*** *DHCS utilizes a tiered compliance rating system to monitor County MHPs and DMC-ODS plans' rates of compliance with contract requirements. County MHPs and counties may move from tier to tier depending on their overall compliance percentage for each review. DHCS may identify the need to improve upon or modify the tiered process to be more effective and efficient.*
- ***Focused Reviews, Focused Training, and Technical Assistance.*** *DHCS conducts focused and/or more frequent reviews regarding compliance deficiencies and potential compliance concerns. Based on the focused reviews, DHCS may provide focused training and technical assistance activities, such as site-specific trainings. Also, the EQRO provides technical assistance to the MCPs for EQRO activities. This includes calls, webinars, email support, and hosting a Quality Conference.*
- ***Monitoring Calls/Webinars.*** *DHCS conducts a monthly call/webinar with all of the County Behavioral Health Departments and the California Behavioral Directors Association (CBHDA). DHCS conducts individual monthly monitoring calls/webinars with each MCMC MCP, County MHP, and DMC-ODS plan. If in the course of monthly monitoring activities, it is determined that a MCMC MCP, County MHP, or DMC-ODS plan requires additional oversight (e.g., increased grievances related to contractual requirements), then DHCS may initiate focused review. DHCS conducts weekly webinars with MCPs and quarterly meetings with MCP Chief Executive Officer's to provide necessary updates that impact the MCPs.*
- ***Quarterly Monitoring.*** *DHCS conducts quarterly monitoring of MCPs by validating each MCP's data submission on network access components (i.e., provider to member ratios, Timely Access Survey results, and out-of-network requests) and member grievances to assess MCPs' compliance with access and member rights. Any instances of noncompliance or insufficient progress on*

previously identified deficiencies require MCPs to provide responses to DHCS. DHCS provides technical assistance to MCPs to correct deficiencies.

Frequency of use:

- *Tiered Review System: Determined Annually*
- *Focused Review and Focused Training/Technical Assistance: As needed*
- *Monitoring Call/Webinar: Monthly for County MHPs and DMC-ODS plans, Weekly and Quarterly for MCPs*
- *Quarterly Monitoring: Quarterly*

How it yields information about the area(s) being monitored: *The tiered review approach yields systemic ways to track County MHPs and DMC-ODS plans' compliance rate changes and allows DHCS to proactively identify potential compliance concerns. The focused review and focused training/technical assistance is an additional monitoring mechanism to address potential compliance issues with additional support for County MHPs and DMC-ODS plans to come into compliance. Monthly all county behavioral health and CBHDA calls provide technical assistance to all county behavior health programs regarding changes, trends, and focused areas affecting the counties' compliance with regulatory and contractual requirements of the SMHS Section 1915(b) waiver. Monthly individual monitoring calls/webinar with each county yield information about the county's progress in corrective action plan implementation and the implementation of any changes and new regulatory and contractual requirements, and provide an opportunity for enhanced monitoring and technical assistance.*

EQRO Technical Assistance yields information about best practices on a range of quality improvement topics. Examples include iterative feedback to MCPs to help them conduct the Plan Do Study Act cycle for PIPs, as well as the EQRO creating a collaborative forum for MCPs to share methods such as those that successfully encouraged participation in women's health screening in immigrant communities and outreach efforts that improved the rate of well child visits in some counties. Weekly meetings are conducted with all MCPs, and quarterly meetings are conducted with all MCP Chief Executive Officers to provide updates, implementations of any changes and new regulatory and contractual requirements. Reoccurring monitoring calls are conducted with MCPs to provide updates and any changes that impact the plan(s) and to ensure MCPs are compliant with all contract reporting and submission requirements. The quarterly monitoring activities analyze MCPs' provider to member ratios, timely access, mandatory provider types, and grievances to ensure MCPs are compliant with contractual requirements outside of the ANC. Any instances of noncompliance are followed up by

DHCS, and MCPs are required to remedy any deficiencies.

Section C: Monitoring Results

Section 1915(b) of the Act and 42 CFR 431.55 require that the State must document and maintain data regarding the effect of the waiver on the accessibility and quality of services as well as the anticipated impact of the project on the State's Medicaid program. In Section B of this waiver preprint, the State describes how it will assure these requirements are met. For an initial waiver request, the State provides assurance in this Section C that it will report on the results of its monitoring plan when it submits its waiver renewal request. For a renewal request, the State provides evidence that waiver requirements were met for the most recent waiver period. Please use Section D to provide evidence of cost-effectiveness.

CMS uses a multi-pronged effort to monitor waiver programs, including rate and contract review, site visits, reviews of External Quality Review reports on MCOs/PIHPs, and reviews of Independent Assessments. CMS will use the results of these activities and reports along with this Section to evaluate whether the Program Impact, Access, and Quality requirements of the waiver were met.

___ This is an initial waiver request. The State assures that it will conduct the monitoring activities described in Section B, and will provide the results in Section C of its waiver renewal request.

X This is a renewal request.

___ This is the first time the State is using this waiver format to renew an existing waiver. The State provides below the results of the monitoring activities conducted during the previous waiver period.

X The State has used this format previously, and provides below the results of monitoring activities conducted during the previous waiver.

For each of the monitoring activities checked in Section B of the previous waiver request, the State should:

Confirm it was conducted as described in Section B of the previous waiver preprint. If it was not done as described, please explain why.

Summarize the results or findings of each activity. CMS may request detailed results as appropriate.

Identify problems found, if any.

Describe plan/provider-level corrective action, if any, that was taken. The State need not identify the provider/plan by name, but must provide the rest of the required information.

Describe system-level program changes, if any, made as a result of monitoring findings.

Please replicate the template below for each activity identified in Section B:

Strategy:

Confirmation it was conducted as described:

___ Yes

___ No. Please explain:

Summary of results:

Problems identified:

Corrective action (plan/provider level)

Program change (system-wide level)

The following monitoring results are applicable to SMHS.

A. Accreditation for Non-Duplication (i.e. if the contractor is accredited by an organization to meet certain access, structure/operation, and/or quality improvement standards, and the state determines that the organization's standards are at least as stringent as the state-specific standards required in 42 CFR 438 Subpart D, the state deems the contractor to be in compliance with the State-specific standards)

N/A

B. Accreditation for Participation (i.e. as prerequisite to be Medicaid plan)

N/A

C. Consumer Self-Report Data

DHCS Response

Strategy 1: Consumer Perception Survey

Confirmation it was conducted as described:

X Yes

___ No. Please explain:

Summary of results:

Consumer perception surveys were conducted using a convenience sampling method. During a one week survey period, twice a year, surveys were provided by counties to consumers and parent/guardians of child consumers who received services from county-operated and contracted providers. The surveys were originally developed and used in compliance with SAMHSA requirements for the Mental Health Block Grant, so surveys were provided to all consumers who received community mental health services (both non-Medi-Cal mental health services as well as Medi-Cal SMHS).

The surveys collected descriptive information from each consumer and included questions about consumer satisfaction with services and whether the services improved their ability to function across several domains. Four types of forms were used: Adult (for ages 18-59), Older Adult (for ages 60+), Youth Services Survey (YSS); for ages 13-17 and transition-age youth who still receive services in the child system, and YSS for Families (YSS-F); for parents/caregivers of youth under age

18)). The forms were available in eight languages: English, Arabic, Chinese, Hmong, Russian, Spanish, Tagalog, and Vietnamese.

The data was analyzed in accordance with the SAMHSA Scoring Protocols for consumer perception surveys. California's Adult and Older Adult Survey items were scored together to yield federal Mental Health Statistics Improvement Program (MHSIP) results; and California's Youth and Caregiver Surveys were scored together to yield federal YSS/YSS-F results.

Below are the results of the convenience sampling process. The percent of positive responses was calculated based on the percent of total mean ratings and scores above 3.5 on the Likert scale (i.e., percent of responses reported as "agree" and "strongly agree").

Percentage of Positive Responses Adults and Older Adults Receiving Services in FY 2015-16:

- *Access 85.2 percent (total responses: 40,709)*
- *Quality and Appropriateness 88.8 percent (total responses: 39,895)*
- *Outcomes 69.7 percent (total responses: 37,696)*
- *Participation in Treatment Planning 79.5 percent (total responses: 38,598)*
- *General Satisfaction with Services 90.2 percent (total responses: 41,128)*
- *Functioning 69.6 percent (total responses: 38,242)*
- *Social Connectedness 67.8 percent (total responses: 38,083)*

Percentage of Positive Responses Youth Receiving Services in FY 2015-16:

- *Access 79.5 percent (total responses: 17,370)*
- *General Satisfaction with Services 84.8 percent (total responses: 17,734)*
- *Outcomes 69.0 percent (total responses: 17,431)*
- *Family Member Participation in Treatment Planning 80.1 percent (total responses: 17,543)*
- *Cultural Sensitivity of Staff 91.0 percent (total responses: 16,802)*
- *Functioning 73.1 percent (total responses: 17,265)*
- *Social Connectedness 82.9 percent (total responses: 17,343)*

Problems identified:

None

Corrective action (plan/provider level):

N/A

Program change (system-wide level):

N/A

DHCS Response

Strategy 2: Onsite Triennial System Review of MHP Beneficiary Satisfaction Policies/Process

Confirmation it was conducted as described:

_**X**_ *Yes*

___ *No. Please explain:*

Summary of results:

During the triennial onsite reviews, State staff reviewed the strategies used by County MHPs related to beneficiary satisfaction. All County MHPs are required to have a mechanism(s) or activity(ies) in place whereby the MHP can regularly gather and measure beneficiary satisfaction. Such mechanisms include but are not limited to surveys, and client focus groups. The County MHPs are asked to provide examples of how they have used satisfaction survey results or outcomes to identify opportunities for improvement and what steps the MHP has taken to make such improvements or address any concerns raised. Examples of changes that might be made are changes to policies, procedures, processes, forms, in addition to treatment services and programs. The County MHPs are required to have baseline statistics with goals for each year.

Average compliance ratings related to the County MHPs having a mechanism in place to regularly gather and measure beneficiary satisfaction are reflected in the table below:

Table 10: Area of Compliance: Beneficiary Satisfaction

Fiscal Year	Number of County MHPs Reviewed	Average Percent Compliance
FY 2014-2015	20	95%
FY 2015-2016	17	100%
FY 2016-2017	19	100%
FY 2017-2018	20	100%
FY 2018-2019	17	94%
AVERAGE LAST THREE-YEAR CYCLE		98%

Problems identified:

Overall there was a high level of compliance in this area. There were a small number of County MHPs identified that did not present adequate documented evidence that the MHP regularly gathered and measured beneficiary satisfaction.

Corrective action (plan/provider level):

County MHPs were required to submit corrective action plans to inform DHCS of actions taken to resolve non-compliance with these requirements. DHCS staff followed up with County MHPs to monitor implementation of the corrective action plans and to provide technical assistance between triennial onsite reviews.

Program change (system-wide level):

N/A

D. Data Analysis (non-claims)

DHCS Response

Strategy 1: Grievance and Appeals: Review and Analysis of MHP Annual Reports

Confirmation it was conducted as described:

_**X**_ Yes

___ No. Please explain:

Summary of results:

County Mental Health Plans submitted to DHCS Annual Beneficiary Grievance and Appeals Reports (ABGAR) which included data on grievances, appeals, expedited appeals and Notices of Adverse Benefit Determinations (NOABD). The grievance and appeals data was analyzed to identify potential trends and/or issues that should be addressed with individual County MHPs or that indicate statewide trends that may require technical assistance or policy clarification. For example, an MHP's data could show a significant increase or decrease in grievances, appeals and NOABDs issued in comparison to the previous three fiscal years.

DHCS staff reviewed all information and reports provided by County MHPs to address any inconsistencies or data incongruities (e.g., sum of individual categories did not add up to totals). Once the accuracy of the information was confirmed, DHCS analyzed the information and identified trends such as County MHPs that reported either unusually high or low numbers of grievances and/or appeals and worked with County MHPs to obtain additional information and/or provide technical assistance.

Pursuant to the 2015—2020 Section 1915(b) SMHS waiver STCs, DHCS submitted annual grievance and appeal reports to CMS.

Corrective Action (plan/provider level):

County MHPs analyzed their data and trends and worked with local quality improvement committees to develop strategies to improve quality of services. DHCS

worked with County MHPs that had unusually low numbers of grievances or appeals to ensure that County MHPs were well informed on the correct grievance and appeals to report and the established reporting mechanism to collect data. For example, one MHP had a significant decrease in grievances and appeals in FY 2017-18 in comparison to FY 2016-17. The MHP was in the process of building an electronic tracking system to centralize the collection of the MHP's grievance, appeals, and NOABD data synchronized which led to significant decrease of data reported. An additional factor in the reduction in grievances was due in large part to a better understanding by MHP staff on how to classify grievances received by the MHP. In previous ABGAR reports, the MHP would include grievances and complaints receive from non-Medi-Cal beneficiaries, including those related to Social Security and services not provided by the MHP. The Patient Rights Manager who has oversight of grievances, worked to ensure the MHP staff correctly categorizes grievances received.

Program change (system-wide level):

DHCS revised the ABGAR reporting form to clarify areas that led to counties submitting inconsistent information since counties appeared to have inconsistent understandings about what information to report and how to report it. DHCS updated and refined definitions and instructions to the ABGAR template in FY 2017-18 and every year after with feedback from County MHPs which resulted in more accurate data reporting.

DHCS Response

Strategy 2: Onsite Triennial System Review: MHP Grievance and Appeals Policies and Procedures

Confirmation it was conducted as described:

_**X**_ Yes

___ No. Please explain:

Summary of results:

All County MHPs are required to have strategies in place to evaluate beneficiary grievances, appeals and fair hearings on an annual basis. During the triennial onsite reviews, State staff reviewed documentation of these strategies and evidence that the annual evaluation occurred. Staff also asked the County MHP to provide examples of grievances or appeals from receipt through resolution.

Average compliance ratings related to the County MHPs evaluation of Beneficiaries Grievances/Appeals as follows:

Table 11: Area of Compliance: Grievances/Appeals

Fiscal Year	Number of County MHPs Reviewed	Average Percent Compliance

FY 2014-2015	*20*	*100%*
FY 2015-2016	*17*	*100%*
FY 2016-2017	*19*	*100%*
FY 2017-2018	*20*	*100%*
FY 2018-2019	*17*	*88%*
AVERAGE LAST THREE-YEAR CYCLE		*96%*

Problems identified:

Overall there is a high level of compliance in this area and there were no significant problems or trends identified during the waiver period. The decrease in compliance in FY 2018-2019 is attributed to only a small number of County MHPs. Corrective action plans were required to be submitted for out-of-compliance items.

Corrective action (plan/provider level):

County MHPs were required to submit a corrective action plan to inform DHCS of actions taken to resolve non-compliance with these requirements. DHCS staff followed up with County MHPs to monitor implementation of the corrective action plans and to provide technical assistance between triennial onsite reviews.

Program change (system-wide level):

N/A

DHCS Response

Strategy 3: Fair Hearing Data

Confirmation it was conducted as described:

_**X**_ Yes

___ No. Please explain:

Summary of results:

The following state hearing data is collected by the California Department of Social Services, State Hearing Division. The total number of filings may not represent the total activity in a given period because a request for a state hearing can be filed in one month and be heard, postponed, withdrawn or adjudicated in the following month(s).

In Calendar Year (CY) 2015-2016, 14 State Hearings concerning Mental Health were reported.

In CY 2016-2017, 47 State Hearings concerning Mental Health were reported.

In CY 2017-2018, 55 State Hearings concerning Mental Health were reported.

In CY 2018-2019, 52 State Hearings concerning Mental Health were reported.

In CY 2019-2020, 40 State Hearings concerning Mental Health were reported.

The summary results from the State Hearing database are as follows:

	CY 2015-2016	***CY 2016-2017***	***CY 2017-2018***	***CY 2018-2019***	***CY 2019-2020***
Total number of Completed State Hearings Filed	*14*	*47*	*55*	*52*	*40*
Case Granted: *Decision for Beneficiary*	*2*	*15*	*11*	*0*	*1*
Case Denied: *Decision for MHP*	*10*	*1*	*5*	*13*	*4*
Case Dismissed: *Nonappearance/No Jurisdiction*	*1*	*18*	*19*	*16*	*12*
Case Withdrawals: *Beneficiary voluntarily withdrew case*	*1*	*13*	*20*	*23*	*23*

The results indicate that while the number of State Hearing cases remained consistent the majority of the cases were filed due to denial of services; however, most of the filed cases were ultimately withdrawn or dismissed. DHCS continues to monitor State Hearings looking for trends which could indicate additional follow up is needed with the County MHPs.

Problems identified:

None

Corrective action (plan/provider level):

NA

Program change (system-wide level):

NA

E. Enrollee Hotlines Operated by State

N/A

F. Focused Studies (detailed investigations of certain aspects of clinical or non-clinical services at a point in time, to answer defined questions. Focused studies differ from performance improvement projects in that they do not require demonstrable and sustained improvement in significant aspects of clinical care and non-clinical service)

N/A

G. Geographic Mapping of Provider Network

N/A

H. Independent Assessment

N/A

I. Measurement of Any Disparities by Racial or Ethnic Groups

DHCS Response

Strategy 1: Review/Analysis of Data

Confirmation it was conducted as described:

_**X**_ Yes

___ No. Please explain:

Summary of results:

Data from a variety of sources is reviewed and analyzed for indicators of potential disparities in beneficiary access to SMHS in the context of race/ethnicity analyzed by gender, age, diagnosis, and other factors when such information is available.

DHCS developed several Mental Health Services Dashboard Demographic datasets that are currently available on the CHHS Open Data Portal here. The datasets were generated from mental health claims, encounters, and eligibility data from FY 2014-15 through 2017-18. They are categorized in two groups: children/youth under 21 and adults 21 and over and can be used to compare and analyze mental health services utilization by race, age, sex, and spoken language.

An Excel-based report tool is also available on both landing pages (links above), which allows users to easily create reports from the Mental Health Services Dashboard Demographics datasets.

Problems identified:

None

Corrective action (plan/provider level):

N/A

Program change (system-wide level):

N/A

Strategy 2: Onsite Triennial System Review: County MHPs Policies/Procedures Regarding Access to Culturally/Linguistically Appropriate Services

Confirmation it was conducted as described:

X *Yes*

___ *No. Please explain:*

Summary of results:

County MHPs are required to address and update strategies and efforts for reducing disparities in access to SMHS and quality and outcome of these services in the context of racial, ethnic, cultural, and linguistic characteristics. Furthermore, all County MHPs are required to have mechanisms or activities in place whereby the County MHP can assess the availability of appropriate cultural/linguistic services within the service delivery capacity of the County MHP. Such mechanism(s) include but are not limited to:

- *A list of non-English language speaking providers in the beneficiary's service areas;*
- *Culture-specific providers and services in the range of programs available;*
- *Beneficiary handbook and provider directory in the MHP's identified threshold languages;*
- *Outreach to underserved target populations informing them of the availability of cultural/linguistic services and programs;*
- *A statewide toll-free telephone number, available 24 hours a day, seven days a week, with language capability in all languages spoken by beneficiaries of the county that will provide information to beneficiaries about access, services, and the use of beneficiary problem resolution/fair hearings; and*
- *Interpreter services.*

During the Section 1915(b) SMHS waiver period from 2015-2021, DHCS implemented revised Cultural Competence Plan Requirements (CCPRs). For more detail on the MHP Cultural Competence Plans, see Strategy 2 under "External Quality Reviews" in this section. In addition to reviewing the CCPR submissions as part of that process, DHCS staff monitored County MHPs' compliance with the CCPRs during the triennial onsite reviews. During the onsite reviews, DHCS staff reviewed information provided by County MHPs to determine MHP compliance with cultural competency requirements.

Average compliance ratings related to the County MHPs informing Limited English Proficient (LEP) individuals, in languages that the LEP individuals understand, that they have a right to free language assistance services are as follows:

Table 12: Area of Compliance: Language Assistance

Fiscal Year	Number of County MHPs Reviewed	Average Percent Compliance
FY 2014-2015	20	90%
FY 2015-2016	17	100%
FY 2016-2017	19	100%
FY 2017-2018	20	100%
FY 2018-2019	17	100%
AVERAGE LAST THREE-YEAR CYCLE		100%

Average compliance ratings related to County MHPs' development of plans and implementation of training programs to improve the cultural competence skills of staff and contract providers, including administrative and management staff; and a process that ensures the interpreters are trained and monitored for language competence are as follows:

Table 13: Area of Compliance: Cultural Competence Training

Fiscal Year	Number of County MHPs Reviewed	Average Percent Compliance
FY 2014-2015	20	95%
FY 2015-2016	17	82%
FY 2016-2017	19	88%
FY 2017-2018	20	80%

FY 2018-2019	*17*	*87%*
AVERAGE LAST THREE-YEAR CYCLE		*85%*

Average compliance ratings related to the County MHPs having a statewide toll-free telephone number available 24 hours a day, seven days a week, with language capability in all languages spoken by beneficiaries of the county that provide information to beneficiaries about access, services, and the use of beneficiary problem resolution/fair hearings are as follows:

Table 14: Area of Compliance: Test Calls

Fiscal Year	Number of County MHPs Reviewed	Average Percent Compliance
FY 2014-2015	*20*	*72%*
FY 2015-2016	*17*	*75%*
FY 2016-2017	*19*	*82%*
FY 2017-2018	*20*	*80%*
FY 2018-2019	*17*	*76%*
AVERAGE LAST THREE-YEAR CYCLE		*79%*

Average compliance ratings related to the County MHPs' test call logs are as follows:

Table 15: Area of Compliance: Test Call Logs

Fiscal Year	Number of County MHPs Reviewed	Average Percent Compliance
FY 2014-2015	*20*	*50%*
FY 2015-2016	*17*	*74%*
FY 2016-2017	*19*	*82%*
FY 2017-2018	*20*	*81%*
FY 2018-2019	*17*	*70%*
AVERAGE LAST THREE-YEAR CYCLE		*78%*

Problems identified:

While there has been significant improvement since FY 2014-2015, County MHPs continue to experience challenges to meet all the requirements of the statewide toll-free 24/7 access line. However, while there are still some instances of County MHPs being out of compliance with specific components of these requirements, in most cases County MHPs are either in compliance or in partial compliance. This is an area of continued focus for training and technical assistance.

Corrective action (plan/provider level):

MHPs were required to submit corrective action plans to inform DHCS of actions taken to resolve non-compliance with these requirements. DHCS staff followed up with the County MHPs to monitor implementation of the corrective action plans and to provide technical assistance between triennial onsite reviews.

Program change (system-wide level):

N/A

J. Network Adequacy Assurance Submitted by Plan (required for MCO/PIHP/PAHP)

DHCS Response

Strategy 1: MHP Contract

Confirmation it was conducted as described:

_***X***_ *Yes*

___ *No. Please explain:*

Summary of results:

During the 2015-2021 1915(b) SMHS waiver, the Medicaid Managed Care and CHIP Managed Care Final Rule (Final Rule) established network adequacy standards in Medicaid and CHIP managed care for certain providers and provides flexibility to states to set state-specific standards.

As a result, DHCS established network adequacy standards pursuant to 42 CFR § 438.68 and 438.206, and 438.207 as specified in Chapter 738, Statutes of 2017, Assembly Bill 205 and CA WIC § 14197.

Each County MHP must maintain and monitor a provider network adequate to serve, within scope of practice under state law, the population of adults and children/youth Medi-Cal beneficiaries eligible for SMHS. County MHPs must meet or exceed network capacity requirements and proportionally adjust the number of network providers to support any anticipated changes in enrollment and the expected utilization of SMHS.

Federal regulations require each MHP to submit to DHCS data and documentation on which the State bases its certification that the MHP has complied with the State's requirements for availability and accessibility of services, including the adequacy of the provider network, as set forth in 42 CFR § 438.68 and 438.206, and 438.207.

DHCS certifies the network of each MHP and submits assurances of adequacy to CMS. DHCS reviews State- and MHP-level data and information, including network data submissions by the County MHPs, to conduct an analysis of the adequacy of each MHP's network. DHCS conducts a comprehensive review of each MHP's provider network in accordance with the annual network certification requirements set forth in 42 CFR §438.207.

California currently has network adequacy standards in place that meet these requirements. The State also maintains network adequacy standards/requirements that exceed those that are required in the Final Rule. Assembly Bill 205 (Chapter 738, Statutes of 2017) codified and amended California's network adequacy standards in CA WIC § 14197.

In addition, the contract between each MHP and DHCS requires County MHPs to report to DHCS when a significant change occurs in the MHP's operation that could impact network adequacy.

The 2018 Network Adequacy Certification was DHCS' inaugural effort to certify the County MHPs' provider networks. DHCS used this network certification review to establish a baseline of each MHP's provider network, as well as to determine targets for improving access to SMHS for Medi-Cal beneficiaries. As such, for the 2018 certification period, DHCS determined that, overall, two County MHPs passed and 54 County MHPs conditionally passed the network certification requirements. For the 2019 Network Adequacy Certification, 27 County MHPs passed and 29 conditionally passed the network certification requirements. For the 2020 Network Adequacy Certification, 13 County MHPs passed and 43 conditionally passed the network certification requirements, which was largely due to the implementation of the Time and Distance Standard requirement, whereas in previous years counties were only required to meet Time or Distance standards. Additionally, for the 2020 certification, timely access standards, language capacity, and continuity of care reports were added as oversight measures.

Problems identified:

Provider-to-Beneficiary ratio, Time and Distance, Timely Access, and Language Line deficiencies.

For the 2018 year, all CAPS were for Time and Distance.

<u>For the 2019 certification year:</u>

- *28 County MHPs were on a corrective action plan for Provider-to-Beneficiary ratio deficiencies. County MHPs can be deficient in more than one category. The details are as follows:*
    - *Six did not meet the Adult Psychiatry Ratio.*

- *15 did not meet the Children/Youth Psychiatry Ratio.*
- *11 did not meet the Adult Outpatient SMHS.*
- *22 did not meet the Children/Youth Outpatient SMHS.*

- *One MHP was on a CAP for Time and Distance but submitted an Alternative Access Standard Request that was approved.*

Of the initial 29 counties on a corrective action plan in 2019, 15 counties were able to resolve these deficiencies.

By the 2020 Certification Year:

- *15 County MHPs were on a corrective action plan for Provider-to-Beneficiary ratio deficiencies. County MHPs can be deficient in more than one category. The details are as follows:*
  - *No counties were deficient in Adult Outpatient SMHS providers.*
  - *Three counties had a corrective action plan in Children/Youth Outpatient SMHS.*
    - *14 had a corrective action plan in Psychiatry services with the majority being in Children/youth Psychiatry*
- *12 County MHPs were on a corrective action plan for Time and Distance. County MHPs can be deficient in meeting Time and Distance standards for more than one service category*
- *Two County MHPs were on a corrective action plan for deficient intensive Care Coordination and Intensive Home Based Services providers.*
- *18 County MHPs were on a corrective action plan for Language Capacity*
- *17 County MHPs were on a corrective action plan for Timely Access*
- *Nine County MHPs were on a corrective action plan for Continuity of Care Report submission.*

To date, out of the initial 43 County MHPs that were on a 2020 Certification Period CAP, only four County MHPs remain on a corrective action plan for Provider-to-Beneficiary ratios. Those counties are Riverside, Plumas, Yolo, and San Joaquin. Marin County and San Mateo County MHPs remain on a corrective action plan for a Timely Access deficiency.

For county-specific corrective action plan information, the reports are located on the DHCS, Network Adequacy page.

Corrective action (plan/provider level):

All counties received findings reports and were placed on corrective action plans that must be fully resolved by January of the year following the advisement of deficiency. The majority of counties were able to resolve deficiencies by the January 2020 corrective action plan resolution timeline. At this time, only four County MHPs remain

on a corrective action plan for provider ratios and two for Time and Distance. Counties that do not resolve deficiencies may be subject to financial or administrative sanctions.

Program change (system-wide level):

N/A

Strategy 2: Onsite Triennial System Review: MHP Policies/Procedures Regarding Numbers and Types of Providers

Confirmation it was conducted as described:

_**X**_ *Yes*

___ *No. Please explain:*

Summary of results:

Each MHP is required to have a QI Work Plan, which includes a description of mechanisms the Contractor has implemented to assess the accessibility of services within its service delivery area and also includes goals for responsiveness for the Contractor's 24-hour toll-free telephone number, timeliness for scheduling of routine appointments, timeliness of services for urgent conditions, and access to after-hours care. The QI plan must also monitor the County MHP's delivery capacity. Specifically, the QI must include goals for the number, types, and geographic distribution of mental health services within the County MHP's provider network.

During the triennial onsite reviews, State staff reviewed information from each MHP regarding the array of services it provides, including the number, type, and geographic distribution of services across the County MHP's provider network. State staff also reviewed each County MHP's QI Work Plan and Work Plan Evaluation to verify that it includes goals for the number, type, and geographic distribution of mental health services within the County MHP's provider network.

Average compliance ratings regarding the County MHPs' goals related to the numbers, types, and geographic distribution of providers are as follows:

Table 16: Area of Compliance: Goals Related to Numbers, Types, and Geographic Distribution of Providers

Fiscal Year	Number of County MHPs Reviewed	Average Percent Compliance
FY 2014-2015	20	72%
FY 2015-2016	17	100%
FY 2016-2017	19	100%

FY 2017-2018	*20*	*98%*
FY 2018-2019	*17*	*88%*
AVERAGE LAST THREE-YEAR CYCLE		*96%*

Problems identified:

In some cases, there was evidence the County MHPs were reviewing data related to number, type, and geographic distribution of mental health services with the QI Committee. While a small number of County MHPs presented some relevant data for review, they did not establish goals for the number, type, and geographic distribution of mental health services in their respective counties. In addition, those County MHPs did not show clear evidence that the QI Committee reviewed data related to the number, type, and geographic distribution of services in the county.

Corrective action (plan/provider level):

County MHPs were required to submit a corrective action plan to inform DHCS of actions taken to resolve non-compliance with these requirements. DHCS implemented a corrective action plan validation process in 2017 to review quality of corrective action plans, and subsequently DHCS improved the process by implementing corrective action plan approval, resolution, and tracking mechanisms in 2019 to provide close monitoring of corrective action plan implementation. DHCS staff continues to follow up with the County MHPs monthly to monitor implementation of the corrective action plans and to provide technical assistance between triennial onsite reviews.

Program change (system-wide level):

N/A

K. Ombudsman

DHCS Response

Strategy 1: Incorporate Ombudsman Unit

Confirmation it was conducted as described:

_***X***_ *Yes*

___ *No. Please explain:*

Summary of results:

During the 2015-2021 Section 1915(b) SMHS waiver period, the Ombudsman Unit within the former Mental Health Division was incorporated into DHCS' Office of the Ombudsman.

The Office of the Ombudsman serves as a resource to help resolve issues between beneficiaries and their MCPs, DMC-ODS plans, and County MHPs. The Office of the Ombudsman helps beneficiaries resolve concerns; offers information and referrals; identifies ways to improve the effectiveness of the County MHPs; educates beneficiaries on how to effectively navigate the Medi-Cal managed care systems; helps beneficiaries find information in order to access appropriate mental health services; connects beneficiaries with the appropriate individuals, departments, and resources to help them resolve their problems; and connects beneficiaries with patients' rights services.

While the Office of the Ombudsman tracks information about the number of mental health-related calls in managed care, it is not feasible to distinguish between nonspecialty mental health and SMHS calls.

Below is an estimate of the number of mental health calls received by the Office of the Ombudsman. These estimates do not reflect the entirety of mental health-related calls that are received, because staff need to choose one call reason from the available options. This means if a caller has multiple issues they are inquiring about, the call will only be logged under one type of issue (e.g., for a call regarding dental services and mental health, the call may be logged as dental and not a mental health-related call).

Table 17: Estimate of Menta Health Calls Received by Office of Ombudsman

Mental Health Calls	Calls Presented	Calls Abandoned	Percent Abandoned	Calls Handled	Percent Calls Handled
2016	1808	269	15%	1539	85%
2017	1655	347	21%	1308	79%
2018	2127	275	13%	1852	87%
2019	2320	358	15%	1968	85%
Q1 2020	736	108	15%	628	85%

Problems identified:

None

Corrective action (plan/provider level):

N/A

Program change (system-wide level):

N/A

L. On-site Review

DHCS Response

Strategy 1: Triennial System Reviews of the MHP

Confirmation it was conducted as described:

_**X**_ *Yes*

___ *No. Please explain:*

Summary of results:

The triennial on-site system reviews of the County MHPs are conducted to determine County MHPs' compliance with State and federal regulations, provisions of the approved Section 1915(b) waiver, and DHCS/County MHP contractual requirements.

During waiver period nine, DHCS implemented a tier system to better track, enhance, and oversee County MHP compliance. Originally there were three tiers, but after further evaluation, DHCS determined that more tiers were needed and, as such, a seven-tier system was implemented. DHCS also completed two County MHP focused reviews with significant or continuing compliance concerns. These reviews focused on a County MHP's specific compliance issues and included more in-depth training and technical assistance.

The average tier placements and compliance findings obtained from FY 2014-2015 through FY 2018-2019 Annual Reviews for Consolidated SMHS and Other Funded Services are summarized in the two tables below.

Table 18: System Review Tier Standings

Tier	In Compliance Range	System Reviews FY 2015-2016 Number/Percent of County MHPs	System Reviews FY 2018-2019 Number/Percent County MHPs
Tier 1	95-100%	23 County MHPs (41%)	29 County MHPs (52%)
Tier 2	90-94%	11 County MHPs (20%)	10 County MHPs (18%)
Tier 3	80-89%	16 County MHPs (29%)	14 County MHPs (25%)
Tier 4	70-79%	4 County MHPs (7%)	2 County MHPs (3%)

Tier 5	*60-69%*	*2 County MHPs (3%)*	*1 MHP (3%)*
Tier 6	*50-59%*	*0 County MHPs (0%)*	*0 County MHPs (0%)*
Tier 7	*0-49%*	*0 County MHPs (0%)*	*0 County MHPs (0%)*

Table 19: Triennial System Reviews

Fiscal Year	Number of County MHPs Reviewed	Total Number of Items in the Annual Protocol	Average Percent In Compliance	Average Percent Out or Partial Compliance
2014-2015	*20*	*151*	*88%*	*11%*
2015-2016	*17*	*187*	*95%*	*12%*
2016-2017	*19*	*200*	*94%*	*5%*
2017-2018	*20*	*245*	*91%*	*6%*
2018-2019	*17*	*365*	*93%*	*8%*
Average last three-year cycle	*18.6*	*270*	*94%*	*6%*

Problems identified:

While the County MHPs have an overall high level of compliance (above 90 percent), some County MHPs experienced challenges with the 24/7 toll-free telephone access and with the written log of initial requests for SMHS.

Corrective action (plan/provider level):

During the 2015-2021 Section 1915(b) SMHS waiver period, DHCS made a concerted effort to work with the County MHPs to improve their compliance with contractual and regulatory requirements through various mechanisms, including providing ongoing training and technical assistance.

During onsite reviews, DHCS staff provide feedback and technical assistance to County MHPs related to out-of-compliance issues, as well as other critical issues for which performance can be improved.

Following the onsite review, County MHPs are notified in writing of all out-of-compliance items. County MHPs are required to submit a corrective action plan for all out-of-compliance items, which is due within 60 days after receipt of the final

report. If the County MHP wishes to appeal any of the out-of-compliance items, the County MHP may do so by submitting an appeal in writing within 15 working days after receipt of the final report.

Once the corrective action plan is received, DHCS staff conducts corrective action plan Validation to determine whether the corrective action plan is complete and is likely to address any out-of-compliance findings. DHCS staff also follows up with the MHP to verify that the corrective action plan has been implemented and is effective and offers continued technical assistance.

In addition, DHCS staff conduct monthly calls with each county to monitor the progress of corrective action plan development, implementation, and resolution, and provide technical assistance. DHCS also conducts a monthly all-county call to provide information and technical assistance.

Program change (system-wide level):

In FY 2014-2015, the review protocol was revised to include an indication of partial compliance, as appropriate, for select items on the protocol in order to give a more accurate picture of the County MHP's level of compliance for each of these items. For example, DHCS conducts test calls of the County MHP's 24/7 access line to determine compliance. In many cases, the County MHP is found to be in compliance with some of the test calls, while others are found to be out of compliance. The designation of partial compliance allows for a more accurate understanding of the County MHP's level of compliance and helps in the identification of the exact nature of the problem.

DHCS is committed to ensuring beneficiaries receive high-quality specialty mental health services and has significantly increased the breadth and depth of our oversight activity in recent years. Staff reorganizations conducted between 2019 and 2020 integrated behavioral health services under the Medicaid director and placed new leadership over the Medi-Cal Behavioral Health Division and oversight branches. New staffing resources, metrics, policies, procedures, and workflows were put into place to streamline and intensify oversight over network adequacy standards and mental health plan contract compliance. The team over contract compliance tripled the staff attention to each county – each liaison now is responsible for three to four counties, instead of ten. Every county on a CAP now must meet with the DHCS liaison at minimum monthly, and the liaison walks through every deficiency and ensures the counties are on a path to improvement; if not, the liaison pushes the county to problem-solve and demonstrate progress with CAP resolution. DHCS also implemented standardized CAP follow-up processes and stronger internal tracking systems to ensure close monitoring and resolution of deficiencies As a result of these comprehensive efforts to strengthen MHP oversight and compliance enforcement, DHCS has achieved accelerated resolutions of CAP findings and greater compliance with contractual and regulatory requirements.

DHCS is also developing a department-wide strategy to align managed care sanctions policies across behavioral health, dental, and medical benefits, consistent

with the goals and principles of mental health parity. Once the sanction policies are established, DHCS plans to implement a new financial sanction program for any county that is found to be deficient and not making progress on network adequacy standards or contract compliance, despite corrective action plans and intensive DHCS monitoring and oversight. DHCS anticipates implementing the new network adequacy sanctions policy for 2022 certification submissions.

Strategy 2: Triennial Outpatient Chart Reviews - Non-Hospital Services (Outpatient) Adult and Children/Youth

Confirmation it was conducted as described:

*_**X**__ Yes*

___ No. Please explain:

Summary of results:

A chart review team, consisting of licensed mental health clinicians, reviews the County MHP's non-hospital services provided to Medi-Cal beneficiaries (half adult charts/half children/youth charts) on a triennial basis. The principal focus of these reviews is to ensure County MHPs and their providers comply with federal and State requirements and the MHP's contractual requirements. The State provides oversight to ensure that the County MHP's claims for SMHS meet medical necessity criteria for reimbursement.

During the waiver period, DHCS implemented a tier system in tracking MHP compliance. Originally there were three tiers but after further evaluation, DHCS determined that more tiers were needed and as such a seven-tier system was implemented.

The average tier placements and compliance findings obtained from FY 2014-2015 through FY 2018-2019 are summarized in the two tables below. As the tables indicate, County MHP compliance rates improved significantly over the waiver period.

Table 20: Chart Review Tier Standings

Tier	In Compliance Range	Chart Reviews FY 2015-2016	Chart Reviews FY 2018-2019
Tier 1	95-100%	3 County MHPs (5%)	17 County MHPs (30%)
Tier 2	90-94%	4 County MHPs (7%)	16 County MHPs (29%)
Tier 3	80-89%	9 County MHPs (16%)	15 County MHPs (27%)

Tier 4	*70-79%*	*8 County MHPs (14%)*	*6 County MHPs (11%)*
Tier 5	*60-69%*	*5 County MHPs (9%)*	*2 County MHPs (3%)*
Tier 6	*50-59%*	*7 County MHPs (13%)*	*0 County MHPs (0%)*
Tier 7	*0-49%*	*20 County MHPs (36%)*	*0 County MHPs (0%)*

Table 21: Triennial Outpatient Chart Reviews

Fiscal Year	Number of County MHPs Reviewed	Number of Claims Reviewed	Number of Claims Disallowed	Percent of Total Claims Disallowed
2014-2015	*20*	*7623*	*3803*	*50%*
2015-2016	*17*	*7615*	*1383*	*18%*
2016-2017	*19*	*6524*	*637*	*10%*
2017-2018	*20*	*6059*	*872*	*14.4%*
2018-2019	*17*	*6605*	*656*	*10%*
Average last three year cycle	*18*	*6396*	*722*	*11%*

Problems identified:

The top five reasons for recoupment in FY 2018-2019 were: 1) the progress note did not match the claim, in terms of the SMHS claimed; 2) the progress note did not match the claim, in terms of time; 3) services were claimed when the planned intervention was not included on the client plan; 4) the service claimed did not meet definition of an SMHS; and 5) progress notes did not clearly include (a) the number of providers and their specific involvement, and/or (b) applicable travel and documentation time.

Corrective action (plan/provider level):

During the 2015-2021 Section 1915(b) SMHS waiver period, DHCS made concerted efforts in working with the County MHPs to make improvements in their chart

documentation through ongoing training and technical assistance, which led to improvements as demonstrated in the tables above.

A written corrective action plan for all out-of-compliance items is required from the MHP within 60 days of the receipt of the final report. The corrective action plan must specify the corrective actions taken to address the items out of compliance. DHCS staff review the corrective action plans, provide follow-up and technical assistance, and ensure the corrective action plans are implemented.

A disallowance is taken for each claim line for which there is insufficient documentation. Disallowances are only taken on claims for services documented in the review sample. There is no extrapolation of the findings.

Program change (system-wide level):

N/A

Strategy 3: SD/MC Hospital Inpatient Reviews

Confirmation it was conducted as described:

*_**X**_ Yes*

___ No. Please explain:

Summary of results:

A summary of the overall and average findings of the inpatient chart reviews are reflected in the table below, which shows significant improvement during the waiver period. Deficiencies are mainly related to documentation of medical necessity for continued stay and documentation for administrative days, specifically documentation of required contacts for placement and the status of those contacts. There has been significant improvement in the hospitals meeting medical necessity and documentation requirements over the past four years.

Table 22: Triennial Short Doyle Medi-Cal Inpatient Psychiatric Hospitals Chart Reviews

Fiscal Year	Number of Hospitals Reviewed	Percent of Acute Days Disallowed	Percent of Administrative Days Disallowed	Percent of Total Days Disallowed
2014-2015	6	50%	58%	54%
2015-2016	6	57%	63%	55%
2016-2017	6	31%	17%	30%
2017-2018	6	18%	5%	23%

2018-2019	*5*	*33%*	*14%*	*30%*
Average last three year cycle	*6*	*30%*	*12%*	*28%*

Problems identified:

The principal reasons for disallowance were that documentation did not meet medical necessity criteria for continued stay services and documentation did not meet criteria for administrative day services. This information enables the State to recoup federal financial participation (FFP) funds for those hospital days that do not meet appropriate regulatory requirements.

Corrective action (plan/provider level):

During the 2015-2021 Section 1915(b) SMHS waiver period, DHCS made concerted efforts to work with County MHPs and the hospitals to make improvements in their chart documentation through ongoing training and technical assistance, which led to improvements as demonstrated in the tables above.

County MHPs are notified of all deficiencies identified during the inpatient review. A disallowance was taken for each claim line for which there was insufficient documentation to support either continued stay services or administrative day services. Disallowances are only taken on claims for services documented in the review sample. There is no extrapolation of the findings. County MHPs are required to submit a corrective action plan, which is reviewed by DHCS staff, and if determined to be deficient, DHCS staff works with the County MHP to revise them.

Program change (system-wide level):

Due to improvements in hospital documentation performance as illustrated above, and to continue implementation of DHCS' parity compliance plan which aligns requirements for MHP authorizations of psychiatric inpatient hospital services with the concurrent authorization review requirements used by MCPs for inpatient hospital services, DHCS will issue additional guidance on concurrent review standards for inpatient psychiatric hospital services. In addition, DHCS will update the triennial review process to audit MHPs for compliance with these concurrent review standards.

Strategy 4: Provider Certification On-Site Reviews

Confirmation it was conducted as described:

_**X**_ *Yes*

___ *No. Please explain:*

Summary of results:

DHCS conducted onsite reviews of county-owned-and-operated providers, and certified or recertified 1,025 providers as eligible to claim for the provision of SMHS. The number of onsite certification reviews of county-owned-and-operated providers continued to increase during this waiver period. In part, this may have been due to the increased need for services resulting from the Affordable Care Act Medicaid Expansion in California and County MHPs being awarded Senate Bill 82 grants for new programs.

County MHPs monitor and track the recertification for their contracted organizational providers. During the 2015-2021 Section 1915(b) SMHS waiver period, DHCS has processed 5,548 certifications and recertifications from the County MHPs for their contracted providers.

Results are reported for FY 2014-2015 through FY 2018-2019 in the table below.

Table 23: Certification and Recertifications of County MHPs

Fiscal Year	County Owned & Operated	MHP Contracted Providers	Total by Fiscal Year
FY 14/15	227	859	1086
FY 15/16	165	1321	1486
FY 16/17	244	1145	1389
FY 17/18	234	1037	1271
FY 18/19	155	1186	1341
Total across waiver period	1025	5548	6573

Problems identified:

There is a high level of compliance with the Medi-Cal certification requirements and no significant trends have been identified. In most cases the provider is able to correct any identified issue(s) while the reviewer is still onsite or within just a few days, such as updating a policy or placing additional informing materials in the lobby.

Corrective action (plan/provider level):

Any corrective action plans issued as a result of an onsite review for identified deficiencies must be resolved prior to certifying and/or recertifying a provider's eligibility to claim Medi-Cal for reimbursement of SMHS.

Program change (system-wide level):

N/A

M. Performance Improvement Projects (required for MCO/PIHP)

DHCS Response

Strategy 1: Performance Improvement Projects

Confirmation it was conducted as described:

_**X**_ *Yes*

___ *No. Please explain:*

Summary of results:

Each County MHP is required to conduct two PIPs. One PIP must be one in a clinical area and the other in a non-clinical area. Clinical PIPs usually focus on outcomes of care, while non-clinical PIPs are geared toward improving service delivery, such as access to and availability of services. During the last waiver reporting period, DHCS increased its efforts in monitoring County MHP performance, including the development and implementation of their PIPs.

The EQRO ensures compliance with PIP submission requirements and the validity of County MHP PIPs. PIP findings are summarized in quarterly PIP reports and one annual technical report. Each report is posted on the EQRO's website. The EQRO also provides DHCS with information regarding PIPs, including topics, activity levels, and status.

The EQRO reports to DHCS on County MHP compliance with PIP requirements. In the FY 2018-19 annual technical report, the EQRO noted that due to the increased monitoring, the EQRO was able to provide technical assistance more frequently. As a result, County MHPs were better able to develop, implement, and complete PIPs, and support continuous quality improvement activities in both clinical and non-clinical aspects of mental health care. Central PIP themes in FY 2018-19 included access to care (24 percent); timeliness to care (17 percent); quality of care (24 percent); and outcomes of care (35 percent). For example, in the fiscal quarter that ended December 31, 2020, one clinical PIP and one non-clinical PIP focused on improving timeliness of services for beneficiaries.

County MHPs also focused on areas such as improvement on maintaining appointments, timeliness to appointments, and follow-up appointments after hospitalization. In addition, the County MHPs' PIPs addressed the well-being of beneficiaries and improvements in their care rather than simply improving MHP processes. The EQRO encouraged County MHPs to continue the trend with a focus on direct interventions that enhance the quality of life of beneficiaries. The EQRO provided significant technical assistance to County MHPs. The EQRO provides technical assistance in person and via conference calls and webinars. The EQRO's website also contains resources that County MHPs can access when needed, including examples of successful PIPs.

Finally, as required by the 2015-2021 Section 1915(b) SMHS waiver STCs, DHCS submitted to CMS the EQRO quarterly and annual reports regarding the required PIPs.

Problems identified:

N/A

Corrective action (plan/provider level):

N/A

Program change (system-wide level):

N/A

N. Performance Measures (required for MCO/PIHP)

DHCS Response

Strategy 1: Measurements of Indicators of Mental Health System Performance on an Ongoing and Periodic Basis

Confirmation it was conducted as described:

_**X**_ *Yes*

___ *No. Please explain:*

Summary of results:

During the 2015-2021 Section 1915(b) SMHS waiver, DHCS implemented the following activities and initiatives regarding system performance:

DHCS continued to implement the consumer perception surveys, which collect descriptive information from each beneficiary and include questions about beneficiary satisfaction with services and whether the services improved their ability to function across several domains. Consumer perception survey results are included above (see Monitoring Results item #1).

In addition, in compliance with 42 CFR § 438.202(a), DHCS prepared its Medi-Cal Managed Care Quality Strategy report, which includes quality strategies across all of California's Medi-Cal managed care delivery systems, including County MHPs.

DHCS also continued its efforts to identify data sources and data collection methodologies for additional quality measures, which have been defined through the POS for SMHS provided to children and youth and SMHS Performance Dashboard stakeholder processes.

The POS, required by CA WIC § 14707.5, and the 2015-2020 Section 1915(b) SMHS waiver STCs, have driven quality improvement efforts for the SMHS program. Through these efforts, both involving collaborative stakeholder processes, DHCS is

defining quality domains and measures and has developed and published MHP performance data.

DHCS considered the following objectives, among others, in developing the POS:

1. *High-quality and accessible mental health services for eligible children and youth, consistent with federal law;*
2. *Information that improves practice at the individual, program, and system levels;*
3. *Minimization of costs by building upon existing resources to the fullest extent possible; and*
4. *Reliable data that are collected and analyzed in a timely fashion.*

The Performance Measurement Paradigm is a conceptual framework for the POS, which was built on the Mental Health Services Act measurement paradigm. DHCS developed the paradigm in collaboration with a wide array of stakeholders. In the paradigm there are four levels for outcomes measurement: individual, provider, system, and community. There are seven domains of measures and indicators in the paradigm, which cross the four levels of outcomes measurement. These domains reflect domains used by SAMHSA. Following are the seven domains selected for the POS measurement paradigm:

- *Access;*
- *Engagement;*
- *Service Appropriateness to Need;*
- *Service Effectiveness;*
- *Linkages;*
- *Cost Effectiveness; and*
- *Satisfaction.*

DHCS publishes three types of POS reports on the DHCS website.

- *Statewide Reports;*
- *Population-Based Reports (Small Rural, Small, Medium, Large, Very Large); and*
- *County-Level Reports.*

Furthermore, the 2015-2021 Section 1915(b) SMHS waiver STCs required DHCS to develop and publish an SMHS Performance Dashboard for each County MHP. The SMHS Performance Dashboards include County MHP performance in the following areas: quality, access, timeliness, and translation/interpretation capabilities.

The Statewide Aggregate SMHS Performance Dashboard and the County-Level SMHS Performance Dashboards are accessible on the DHCS website here.

Benchmarks and performance targets for SMHS are evolving areas, and DHCS continues efforts to determine appropriate benchmarks and performance targets related to SMHS.

The quality indicators currently reported for SMHS are outlined below:

- *Access*
    - *Number of children and adults that received SMHS*
- *SMHS Penetration Rate*
    - *Received one or more SMHS visits: proportion of beneficiaries eligible for SMHS who received one or more SMHS visits*
    - *Received five or more SMHS visits: proportion of beneficiaries eligible for SMHS who received five or more SMHS visits*
- *Time to Step Down*
    - *Time between Inpatient Discharge and Step Down Service*
- *Utilization: Approved SMHS*
    - *Expenditures and Service Quantity per Beneficiary: service utilization in minutes by unique beneficiary and service type*
- *Satisfaction*
    - *General Satisfaction (youth and adult surveys)*
    - *Perception of Participation in Treatment Planning (youth and adult surveys)*
    - *Perception of Access (youth and adult surveys)*
    - *Perception of Cultural Sensitivity (youth and adult surveys)*
    - *Perception of Quality and Appropriateness (adult surveys)*
    - *Perception of Outcomes of Services (youth and adult surveys)*
    - *Perception of Functioning (youth and adult surveys)*
    - *Perception of Social Connectedness (youth and adult surveys)*

Finally, the EQRO also reviews and validates performance measures as part of their external quality review of County MHPs. The performance measures reviewed by the EQRO include the following:

- *Total beneficiaries served by each County MHP*
- *Penetration rates in each County MHP*
- *Total costs per beneficiary served by each County MHP*
- *Penetration rates for vulnerable and underserved populations*

- *Stratified by race/ethnicity Foster Care*

- *Approved claims for vulnerable and underserved populations*
  - *Stratified by race/ethnicity Foster Care*
- *High-Cost Beneficiaries (HCBs), incurring approved claims of $30,000 or higher during a calendar year (CY)*
- *Count of Therapeutic Behavioral Services (TBS) beneficiaries served compared to the four percent Emily Q. benchmark*
- *Psychiatric inpatient hospital seven-day and 30-day rehospitalization rates*
- *Post-psychiatric inpatient hospital seven-day and 30-day SMHS follow-up service rates*
- *Total psychiatric inpatient hospital episodes, costs, and average length of stay (LOS)*
- *Beneficiary counts by diagnostic groups*
- *Approved claims by diagnostic groups*
- *Affordable Care Act (ACA) analysis:*
  - *Eligibles and beneficiaries served*
  - *Penetration rates*
  - *Approved claims per beneficiary (ACB)*
  - *Beneficiary counts by diagnostic groups*
  - *Approved claims by diagnostic groups*

The FY 2019-20, EQRO performance measures report may be accessed here.

Problems identified:

None

Corrective action (plan/provider level):

N/A

Program change (system-wide level):

N/A

Strategy 2: Implementation Plans

Confirmation it was conducted as described:

_***X***_ *Yes*

___ *No. Please explain:*

Summary of results:

The Implementation Plan is required by State regulations when a County MHP begins operation. The State has approved the Implementation Plans for all current County MHPs. State regulations require County MHPs to submit proposed changes to their Implementation Plans to the State in writing, prior to the implementation of the proposed changes. There were no new County MHPs started during this reporting period, therefore all implementation plans submitted were updates. The State approved twelve submitted Implementation Plan updates received during the 2015-2021 Section 1915(b) SMHS waiver period. Updates included updates to point of contact information or to bring the implementation plan into compliance with newly issued guidance.

Problems identified:

None

Corrective action (plan/provider level):

N/A

Program change (system-wide level):

N/A

Strategy 3: Onsite Triennial System Review: County MHPs Quality Improvement (QI) Program

Confirmation it was conducted as described

_***X***_ *Yes*

___ *No. Please explain:*

Summary of results:

County MHPs are required to have a QI program. The purpose of the QI program is to review and improve the quality of SMHS provided to beneficiaries. The QI Program must have active participation by the County MHP's providers, as well as beneficiaries and family members. During the triennial system reviews, DHCS reviewed each County MHP's QI work plan for evidence of QI activities that the County MHP has engaged in, including recommending policy changes, evaluation of QI activities, instituting needed actions, and ensuring follow-up of QI processes and previously identified issues. The County MHPs also provided evidence of mechanisms in place to evaluate the effectiveness of the QI program and how QI activities have contributed to improvements in clinical care and beneficiary services. The County MHPs are required to review the QI work plan and revise as appropriate on an annual basis. During the triennial system review, DHCS reviewed both the QI work plan itself and evidence that activities identified in the work plan were implemented.

Average compliance ratings related to the County MHPs' QI activities are reflected in the table below:

Table 24: Area of Compliance: Quality Improvement Activities

Fiscal Year	Number of County MHPs Reviewed	Average Percent Compliance
FY 2014-2015	20	92%
FY 2015-2016	17	100%
FY 2016-2017	19	100%
FY 2017-2018	20	96%
FY 2018-2019	17	97%
AVERAGE LAST THREE-YEAR CYCLE		98%

Problems identified:

There is a high level of compliance across County MHPs in the area of Quality Improvement activities. No significant issues or trends were identified.

Corrective action (plan/provider level):

County MHPs were required to submit a corrective action plan to inform DHCS of actions taken to resolve noncompliance with these requirements. DHCS' staff follows up with the County MHPs to monitor implementation of the corrective action plans and to provide technical assistance between triennial onsite reviews.

Program change (system-wide level):

N/A

O. Periodic Comparison of Number and Types of Medicaid Providers Before and After Waiver

Strategy 1: Provider Comparison Before/After Waiver

Confirmation it was conducted as described:

___ Yes

__X__ No. Please explain:

Summary of results:

DHCS does not have information regarding the number of providers that existed prior to the implementation of the first Section 1915(b) SMHS waiver – which was

implemented in the mid-1990s. As a result, DHCS is not able to conduct a comparison between the number of current SMHS providers with the number of providers prior to the implementation of the first waiver. DHCS is discontinuing this monitoring activity, as data on the number of providers prior to the waiver is not available.

Problems identified:

None

Corrective action (plan/provider level):

N/A

Program change (system-wide level):

N/A

P. Profile Utilization by Provider Caseload (looking for outliers)

N/A

Q. Provider Self-Report Data

N/A

R. Test 24 Hours/7 Days a Week PCP Availability

N/A

S. Utilization Review (e.g. ER, non-authorized specialist requests)

DHCS Response

Strategy 1: MHP Utilization Review Management Program (UMP): Payment Authorization System

Confirmation it was conducted as described:

_**X**_ Yes

___ No. Please explain:

Summary of results:

County MHPs are required to have utilization management programs that evaluate medical necessity, appropriateness and efficiency of services provided to beneficiaries. All County MHP's Utilization Management Plans reviewed during the waiver period contained requirements related to consistent application of medical and service necessity in payment authorization systems.

Problems identified:

None

Corrective action (plan/provider level):

N/A

Program change (system-wide level):

N/A

T. Other (please describe)

DHCS Response

Strategy 1: External Quality Reviews (EQRs)

Confirmation it was conducted as described:

_***X***_ *Yes*

___ *No. Please explain:*

Summary of results:

As required by 42 CFR § 438, Subpart E, DHCS contracts with an EQRO. The EQRO conducts annual reviews of County MHPs to analyze and evaluate information related to quality, timeliness, and access to SMHS provided by County MHPs and/or their subcontractors to Medi-Cal beneficiaries.

EQRO reviews consist of site visits, consumer (beneficiary) and family member focus groups, County MHP and provider staff focus groups, data analysis and reporting, information system reviews, and the evaluation of County MHP Performance Improvement Projects.

Each EQRO review is summarized in an individualized MHP report. Information included in individualized County MHP reports is also included in an annual statewide summary report. In addition to individualized MHP reports and the annual statewide summary report, BHC publishes quarterly PIP reports. The Medi-Cal Specialty Mental Health EQR, FY 2018-19 Statewide Report can be found here.

In addition, in accordance with the 2015-2021 Section 1915(b) SMHS Waiver STCs, DHCS submitted EQRO's quarterly PIP reports and annual summary report to CMS.

Problems identified:

None

Corrective action (plan/provider level):

N/A

Program change (system-wide level):

N/A

Strategy 2: Cultural Competence Plans (CCPs)

Confirmation it was conducted as described:

_**X**_ *Yes*

___ *No. Please explain:*

Summary of results:

County MHPs are required to develop and implement CCPs that include objectives for reducing disparities by tailoring best practices in mental health services to beneficiaries' cultural and ethnic backgrounds and language preferences. County MHPs must update their CCPs and submit those updates to DHCS for review and approval annually.

During the 2015-2021 Section 1915(b) SMHS waiver, DHCS worked with subject matter experts in the field of cultural competence to incorporate the enhanced national standards published in 2013 by the U.S. Department of Health & Human Services Office of Minority Health into the statewide CCPRs. The CCPRs offer a strong framework for tailoring mental health services to the beneficiaries' culture and language preferences as well as the provision of high-quality mental health care. The CCPRs address the entire public mental health delivery system by focusing on the following eight domains:

- *Organizational commitment to cultural competence;*
- *Assessment of population and service needs;*
- *Strategies and efforts for reducing disparities;*
- *Participation of client, family, and community members in the delivery system;*
- *Culturally competent training activities;*
- *Commitment to growing a multicultural workforce;*
- *Language capacity; and*
- *Adaptation of services to meet the needs of beneficiaries.*

During FY 2018-19, DHCS conducted an analysis of County MHPs' CCP updates to identify strategies that County MHPs are using to reduce disparities, and to determine common mental health disparities and/or strategies for addressing them among County MHPs. The CCPs addressed social determinants of health, including family dynamics and living arrangements, which influence mental health risk and outcomes, particularly for children and youth in the foster care system.

The CCP findings for FY 2017-18 and 2018-19 indicate that factors such as culture, ethnicity, and language influence mental health risk and outcomes. The availability of bilingual clinicians, and clinicians that are familiar with or share the same cultural background as the beneficiaries they serve, can help beneficiaries engage in and

benefit from mental health services, leading to improved outcomes. There is also a growing trend at some County MHPs to use trauma-informed care as a cultural competence component to provide trauma-informed services. These services focus on recovery and are strength based, client and family driven, and culturally competent.

Finally, during FY 2018-19, an analysis of CCP information found that County MHPs use community-informed and culturally competent practices that meet the needs of their diverse communities in accessing SMHS.

Problems identified:

No County MHPs were out of compliance with the CCP requirement. However, County MHPs have not met all of DHCS' equity goals. DHCS is in the process of revamping CCPRs to increase expectations of the plans related to culturally responsive care and achieving equitable outcomes.

Corrective action (plan/provider level):

TBD as new standards are developed.

Program change (system-wide level):

DHCS has contracted with an expert consultant, the Center for Applied Research Solutions, to work with counties to identify and address disparities in care and to improve their delivery of culturally responsive care.

Strategy 3. A.: Compliance Advisory Committee (CAC)

Confirmation it was conducted as described:

_X_ *Yes*

___ *No. Please explain:*

Summary of results:

The Compliance Advisory Committee (CAC) offers stakeholders an invaluable opportunity to provide feedback and recommendations relative to DHCS' compliance protocol and review process. This ongoing relationship between DHCS and the CAC ensures stakeholders have a significant voice in how quality and access are monitored.

During the Section 1915(b) SMHS waiver period from 2015-2021, annual CAC meetings were held on the following dates:

Fiscal Year	CAC Meeting Date
FY 2014-2015	August 8, 2014
FY 2015-2016	July 30, 2015
FY 2016-2017	July 26, 2016

FY 2017-2018	*August 14, 2017*
FY 2018-2019	*August 31, 2018*
FY 2019-2020	*July 29, 2019*

Certain revisions to the compliance protocol and review process recommended by the CAC were implemented. For example, one major revision during the five-year waiver period included adding an indication of partial compliance in FY 2014-15, as appropriate, for select items on the protocol, which allows the State, as well as the County MHP, to have a more complete understanding of the level of compliance in these areas. Other changes during this period have included the addition of the new requirements related to the Managed Care Rule. The CAC's feedback and recommendations help shape the discussion around proposed changes to the protocol and help determine the process for implementing the recommended changes.

Problems identified:

None

Corrective action (plan/provider level):

N/A

Program change (system-wide level):

N/A

Strategy 3. B.: Cultural Competence Advisory Committee (CCAC)

Confirmation it was conducted as described:

___ *Yes*

_**X**_ *No. Please explain: DHCS did not implement a CCAC, as originally planned, and instead formed a broader Behavioral Health Stakeholder Advisory Committee (BH-SAC), which includes a focus on cultural competence.*

Summary of results:

DHCS formed the BH-SAC in 2019 to facilitate stakeholder input on behavioral health policy, including culturally responsive care and health equity. The BH-SAC consists of leaders from County MHPs, providers, associations, advocates, consumer representatives, and others. The October 2020 meeting, for example, was predominantly devoted to collecting input from BH-SAC members on how to improve the delivery of culturally responsive care and how to eliminate health inequities. In addition, DHCS convenes ad hoc stakeholder workgroups to develop input on issues related to culturally responsive care, such as a project launching that launched in

early 2021 to provide training and technical assistance to counties on culturally responsive care and health equity. DHCS held a workgroup to collect input on the design of the program and scope of work for the contractor. In this effort, DHCS will be working collaboratively with the California Department of Public Health Office of Health Equity to enhance County MHPs' cultural competence and quality improvement programs, increase provider capacity, engage community-based organizations to become Medi-Cal-certified providers, and achieve population-specific approaches to reduce disparities in access to mental health services.

Problems identified:

None

Corrective action (plan/provider level):

N/A

Program change (system-wide level):

N/A

DHCS Response

Strategy 3. C.: California Mental Health Planning Council (CMHPC)

Confirmation it was conducted as described:

_***X***_ *Yes*

___ *No. Please explain:*

Summary of results:

DHCS continued to work with its federal- and State-mandated California Behavioral Health Planning Council (CBHPC, previously known as the Mental Health Planning Council; name was changed to include SUD), which is a majority consumer and family member advisory body to State and local government, the Legislature, and residents of California on mental health services in California. The CBHPC is designed to advocate for children with serious emotional disturbance (SED) and adults with serious mental illness (SMI).

The vision and mission of the CBHPC guides its evaluation of California's system of behavioral health care through targeted committee studies, community site visits, and General Session forums and presentations. The CBHPC informs the Administration and the Legislature on priority issues and provides feedback on behavioral health policy and regulations and on legislative actions based on our Policy Platform. The Administration regularly attends the Council's quarterly meetings and shares key policy initiatives, including but not limited to the development of behavioral health policy in CalAIM, the development of the proposed SMI/SED IMD 1115 demonstration, the department's response to public health emergencies, and CalHOPE. The Council provides feedback during committee

meetings, formally through written feedback, and through representatives on the BH-SAC.

Problems identified:

None

Corrective action (plan/provider level):

N/A

Program change (system-wide level):

N/A

Strategy 4: Provider Appeals

Confirmation it was conducted as described:

_**X**_ Yes

___ No. Please explain:

Summary of results:

Strategy 4.1.: Inpatient Service Treatment Authorization Requests (TAR) State Appeals: Fee for Service (FFS) Hospitals

County MHPs are required to have a provider problem resolution process. When an appeal concerns a dispute about payment for emergency psychiatric inpatient hospital services, providers may appeal to the State if the County MHP denies the appeal in whole or in part. Such appeals to the State are generally referred to as "State/second-level TAR appeals."

- *In FY 2015-16, DHCS received 131 State/second level TAR appeals from providers.*
- *In FY 2016-17, DHCS received 72 State/second level TAR appeals from providers.*
- *In FY 2017-18, DHCS received 284 State/second level TAR appeals from providers.*
- *In FY 2018-19, DHCS received 214 State/second level TAR appeals from providers*
- *As of March 1, FY 2019-20, DHCS received 103 State/second level TAR appeals from providers.*

A majority of second-level TAR appeals were filed by small individual providers. DHCS upheld the County MHP's decision for 92 percent of days appealed through the State/second-level TAR appeal process.

The high percentage of second-level TAR appeal denial decisions is primarily based upon the failure of providers to meet documentation standards related to

medical necessity criteria for acute and administrative days, such as failure to document the required number of phone calls to facilities to allow step-down to a lower level of care.

Problems identified:

None

Corrective action (plan/provider level):

N/A

Program change (system-wide level):

N/A

Strategy 4.2.: Appeals Regarding Specialty Mental Health Services

Summary of results:

Overall, the number of provider appeals have been low within the 2015–2020 Section 1915(b) SMHS waiver period. During this period, 12 inpatient appeals were filed, 23 outpatient appeals were filed, and ten EPSDT informal appeals were filed; the resolution of one informal appeal is still pending. These results likely are due in large part to DHCS technical assistance, policy clarifications, and trainings on clinical documentation.

Problems identified:

None

Corrective action (plan/provider level):

N/A

Program change (system-wide level):

N/A

Strategy 5: County Support Unit

Confirmation it was conducted as described:

_***X***_ *Yes*

___ *No. Please explain:*

Summary of results:

DHCS has dedicated staff that function as the central point of contact for County MHPs. Staff provides resources and technical assistance to support counties in the provision of SMHS. There is an assigned DHCS liaison to each county.

DHCS staff provided technical assistance to County MHP contact staff on the development of the corrective action plans in response to triennial review items that were out of compliance with standards.

Prior to upcoming system reviews, DHCS staff contacted County MHPs to request updates on evidence of correction from the previous triennial review. Based on MHP status, DHCS staff offered consultation and technical assistance as the MHP prepared for the review. DHCS staff continued to regularly follow up with MHP staff until the time of the system review.

After submission of the corrective action plans, DHCS staff worked with County MHPs to obtain evidence of correction for corrective action plans in priority areas including Access, Beneficiary Protection, Quality Improvement, Program Integrity, and any repeat corrective action plan items from the previous review. After evidence of correction was submitted, DHCS staff continued to interact with County MHPs and request evidence of continued correction as needed to confirm continued implementation of corrective action plans.

DHCS staff determined that the following were of the highest priority for follow-up: 24/7 access lines, grievance and appeal processes, timeliness of access to services, as well as quality improvement activities. DHCS staff tracked County MHP progress in these specific areas.

Problems identified:

DHCS identified 24/7 access line requirements as statewide compliance concerns.

Corrective action (plan/provider level):

DHCS staff participated in one focused review for one county that needed additional assistance to meet state requirements analogous to reports of similar issues from other counties. The technical assistance, in the form of regularly scheduled contacts, continued for several months and DHCS staff worked with the county to obtain evidence of correction and ensure that requirements were met. The County MHP has made significant improvement.

Based on DHCS staff analysis of statewide trends from the system reviews during the last three years, we have identified 24/7 access line requirements as an area for focused statewide technical assistance. As a result, County MHPs' internal test call frequency and scripts are reviewed by DHCS staff on a quarterly basis.

Program change (system-wide level):

N/A

***In addition to the above monitoring results, DHCS also implemented the following STCs as requested by CMS**:*

1. *The State made available to beneficiaries, providers, and other interested stakeholders a mental health plan dashboard that is based on performance data of each County MHP included in the annual CalEQRO technical report and/or other appropriate resources. Each County MHP dashboard is posted on the State's and the County MHP website.*

2. *The State required each County MHP to commit to having a system in place for tracking and measuring timeliness of care, including wait times to assessments and wait time to providers.*
3. *The State provided the CalEQRO's quarterly and annual reports regarding the required PIPs to CMS, and discussed these findings during monthly monitoring calls.*
4. *The State published on its website the County MHPs' Plan of Correction as a result of the State compliance reviews. The State and County MHPs published the county mental health QI Plan. The intent was to be able to identify the County MHP's goals for quality improvement and compliance.*
5. *The State and the County MHPs provided to CMS the annual grievance and appeals reports by November 1 of each year.*
6. *All information required to be published pursuant to these STCs is placed in a standardized and easily accessible location on the State's website.*
7. *The State, within the timeframes specified in law, regulation, or policy statement, came into compliance with any changes in federal law, regulation, or policy affecting the Medicaid or CHIP programs that occurred during this waiver period.*

Section D – Cost-Effectiveness

Please follow the Instructions for Cost-Effectiveness (in the separate Instructions document) when filling out this section. Cost-effectiveness is one of the three elements required of a 1915(b) waiver. States must demonstrate that their waiver cost projections are reasonable and consistent with statute, regulation and guidance. The State must project waiver expenditures for the upcoming two-year waiver period, called Prospective Year 1 (P1) and Prospective Year 2 (P2). The State must then spend under that projection for the duration of the waiver. In order for CMS to renew a 1915(b) waiver, a State must demonstrate that the waiver was less than the projection during the retrospective two-year period.

A complete application includes the State completing the seven Appendices and the Section D. State Completion Section of the Preprint:

Appendix D1. Member Months
Appendix D2.S Services in the Actual Waiver Cost
Appendix D2.A Administration in the Actual Waiver Cost
Appendix D3. Actual Waiver Cost
Appendix D4. Adjustments in Projection
Appendix D5. Waiver Cost Projection
Appendix D6. RO Targets
Appendix D7. Summary Sheet

States should complete the Appendices first and then describe the Appendices in the State Completion Section of the Preprint. Each State should modify the spreadsheets to reflect their own program structure. Technical assistance is available through each State's CMS Regional Office.

Part I: State Completion Section

A. Assurances

a. [Required] Through the submission of this waiver, the State assures CMS:

- The fiscal staff in the Medicaid agency has reviewed these calculations for accuracy and attests to their correctness.
- The State assures CMS that the actual waiver costs will be less than or equal to or the State's waiver cost projection.
- Capitated rates will be set following the requirements of 42 CFR 438.6(c) and will be submitted to the CMS Regional Office for approval.
- Capitated 1915(b)(3) services will be set in an actuarially sound manner based only on approved 1915(b)(3) services and their administration subject to CMS RO prior approval.
- The State will monitor, on a regular basis, the cost-effectiveness of the waiver (for example, the State may compare the PMPM Actual

Waiver Cost from the CMS 64 to the approved Waiver Cost Projections). If changes are needed, the State will submit a prospective amendment modifying the Waiver Cost Projections.

- The State will submit quarterly actual member month enrollment statistics by MEG in conjunction with the State's submitted CMS-64 forms.

b. Name of Medicaid Financial Officer making these assurances: ***Lindy Harrington***

c. Telephone Number: ***(916) 322-4831***

d. E-mail: ***Lindy.Harrington@dhcs.ca.gov***

e. The State is choosing to report waiver expenditures based on

__X__ date of payment *(Applies to SMHS, DMC-ODS)*.

__X__ date of service within date of payment. The State understands the additional reporting requirements in the CMS-64 and has used the cost effectiveness spreadsheets designed specifically for reporting by date of service within day of payment. The State will submit an initial test upon the first renewal and then an initial and final test (for the preceding 4 years) upon the second renewal and thereafter. *(Applies to MCMC, Dental MC)*

DHCS Response

DHCS is reporting base and projected waiver expenditures on a date of payment basis for SMHS and DMC-ODS and a date of service basis for MCMC and Dental MC. The date of payment basis is consistent with existing and previous reporting for SMHS and DMC-ODS due to the cost-based financing and payment methodology for behavioral health services. Under CalAIM, DHCS aims for further delivery system integration and administrative simplification. When DHCS moves to a rate-based financing and payment methodology for behavioral health services, DHCS will be able to align waiver expenditure reporting for MCMC, Dental MC, SMHS, and DMC-ODS on a date of service basis.

B. For Renewal Waivers only (not conversion)- Expedited or Comprehensive Test—

To provide information on the waiver program to determine whether the waiver will be subject to the Expedited or Comprehensive cost effectiveness test. *Note: All waivers, even those eligible for the Expedited test, are subject to further review at the discretion of CMS and OMB.*

a.__ The State provides additional services under 1915(b)(3) authority.

b.__X__ The State makes enhanced payments to contractors or providers. *(Applies to MCMC, Dental MC)*

c. ___ The State uses a sole-source procurement process to procure State Plan services under this waiver.

d.___ Enrollees in this waiver receive services under another 1915(b) waiver program that includes additional waiver services under 1915(b)(3) authority; enhanced payments to contractors or providers; or sole-source procurement processes to procure State Plan services. *Note: do not mark this box if this is a waiver for transportation services and dental pre-paid ambulatory health plans (PAHPs) that has overlapping populations with another waiver meeting one of these three criteria. For transportation and dental waivers alone, States do not need to consider an overlapping population with another waiver containing additional services, enhanced payments, or sole source procurement as a trigger for the comprehensive waiver test. However, if the transportation services or dental PAHP waiver meets the criteria in a, b, or c for additional services, enhanced payments, or sole source procurement then the State should mark the appropriate box and process the waiver using the Comprehensive Test.*

If you marked any of the above, you must complete the entire preprint and your renewal waiver is subject to the Comprehensive Test. If you did not mark any of the above, your renewal waiver (not conversion or initial waiver) is subject to the Expedited Test:

- Do not complete **Appendix D3**
- Attach the most recent waiver Schedule D, and the corresponding completed quarters of CMS-64.9 waiver and CMS-64.21U Waiver and CMS 64.10 Waiver forms, and
- Your waiver will not be reviewed by OMB *at the discretion of CMS and OMB*.

The following questions are to be completed in conjunction with the Worksheet Appendices. All narrative explanations should be included in the preprint. Where further clarification was needed, we have included additional information in the preprint.

C. Capitated portion of the waiver only: Type of Capitated Contract

The response to this question should be the same as in **A.I.b**.

a.__**X**__ MCO *(Applies to MCMC)*

b.__**X**__ PIHP *(Applies to SMHS, DMC-ODS)*

c.__**X**__ PAHP *(Applies to Dental MC)*

d.___ Other (please explain):

D. PCCM portion of the waiver only: Reimbursement of PCCM Providers *[NOT APPLICABLE]*

Under this waiver, providers are reimbursed on a fee-for-service basis. PCCMs are reimbursed for patient management in the following manner (please check and describe):

a.___ Management fees are expected to be paid under this waiver. The management fees were calculated as follows.

1.___ First Year: $____ per member per month fee
2.___ Second Year: $____ per member per month fee
3.___ Third Year: $____ per member per month fee
4.___ Fourth Year: $____ per member per month fee

b.___ Enhanced fee for primary care services. Please explain which services will be affected by enhanced fees and how the amount of the enhancement was determined.

c.___ Bonus payments from savings generated under the program are paid to case managers who control beneficiary utilization. Under **D.I.H.d.**, please describe the criteria the State will use for awarding the incentive payments, the method for calculating incentives/bonuses, and the monitoring the State will have in place to ensure that total payments to the providers do not exceed the Waiver Cost Projections (Appendix D5). Bonus payments and incentives for reducing utilization are limited to savings of State Plan service costs under the waiver. Please also describe how the State will ensure that utilization is not adversely affected due to incentives inherent in the bonus payments. The costs associated with any bonus arrangements must be accounted for in Appendix D3. Actual Waiver Cost. d.___ Other reimbursement method/amount. $_____ Please explain the State's rationale for determining this method or amount.

E. Appendix D1 – Member Months

Please mark all that apply.

For Initial Waivers only: *[NOT APPLICABLE]*

a.___ Population in the base year data
1.___ Base year data is from the same population as to be included in the waiver.
2.___ Base year data is from a comparable population to the individuals to be included in the waiver. (Include a statement from an actuary or other explanation, which supports the conclusion that the populations are comparable.)

b.___ For an initial waiver, if the State estimates that not all eligible individuals will be enrolled in managed care (i.e., a percentage of individuals will not be enrolled because of changes in eligibility status and the length of the enrollment process) please note the adjustment here.

c.___ [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:
_____

d. ___[Required] Explain any other variance in eligible member months from BY to P2: _____

e.____[Required] List the year(s) being used by the State as a base year:____. If multiple years are being used, please explain:_____

f.____ [Required] Specify whether the base year is a State fiscal year (SFY), Federal fiscal year (FFY), or other period _____.

g.____[Required] Explain if any base year data is not derived directly from the State's MMIS fee-for-service claims data:

_____

For Conversion or Renewal Waivers:

a. **X** [Required] Population in the base year and R1 and R2 data is the population under the waiver. *(Applies to MCMC, Dental MC, SMHS, DMC-ODS)*

b. **X** For a renewal waiver, because of the timing of the waiver renewal submittal, the State did not have a complete R2 to submit. Please ensure that the formulas correctly calculated the annualized trend rates. *Note: it is no longer acceptable to estimate enrollment or cost data for R2 of the previous waiver period. (Applies to MCMC, Dental MC, SMHS, DMC-ODS)*

DHCS Response

DHCS adjusted the formulas to calculate the annualized trend rates correctly.

c. **X** [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:

DHCS Response

MCMC and Dental MC: *The base year member months include all Medi-Cal managed care populations under the waiver enrolled in State Fiscal Year (SFY) 2018-19. Although total member months in P1 are anticipated to be higher due to the moratorium on eligibility redeterminations during the public health emergency, with subsequent decreases anticipated in P2 and P3 due to the resumption of eligibility determinations, at this time DHCS is not projecting an increase or decrease in member months over the term of the waiver for purposes of the cost-effectiveness calculation, with one exception in P2 (described further below). Due to the high number of programmatic/policy/pricing change adjustments applicable to MCMC and Dental MC, DHCS believes that holding member months constant facilitates the identification and review of the impact of changes applicable during each year of this waiver. DHCS will continue to monitor caseload and may, in the future, work with CMS to amend the cost-effectiveness calculation to reflect an updated projection – especially if any changes to caseload are anticipated to materially change the per-capita expenditure level projected for an eligibility grouping.*

A caseload increase is assumed in P2 for the SPD and SPD Dual eligibility groups due to the mandatory enrollment, with certain exceptions, of dually eligible beneficiaries into the Medi-Cal managed care delivery system on a statewide basis. In the base year and in P1, dually eligible beneficiaries are mandatorily enrolled, with certain exceptions, into the Medi-Cal managed care delivery system in 27 of California's counties, i.e., County Organized Health System (COHS) and Coordinated Care Initiative (CCI) counties. The increase to P2 projected member months consists of 205,000 additional members months in the SPD eligibility group (roughly equivalent to 17,000 partial-dually eligible members per month) and 3,660,000 additional member months in the SPD Dual eligibility group (equivalent to 305,000 full-dually eligible members per month).

SMHS and DMC-ODS: *DHCS is projecting an increase in member months in P1 due to the moratorium on eligibility redeterminations during the public health emergency. It is likely to take a year to bring current all redeterminations. Member months decrease in P2 and P3 due to the resumption of eligibility determinations and is consistent with California's decline in Medi-Cal enrollment prior to the COVID-19 Public Health Emergency (PHE). The base year member months data includes all Medi-Cal beneficiaries enrolled in State Fiscal Year 2018-19, which includes quarter ending September 30, 2018 through quarter ending June 30, 2019.*

On May 1, 2022, DHCS began enrolling non-citizens with unsatisfactory immigration status who are over 49 years of age in its State Only Medi-Cal program. By January 2024, DHCS will begin enrolling non-citizens with unsatisfactory immigration status between the ages of 26 and 49 in its State Only Medi-Cal program. Non-citizens with unsatisfactory immigration status are eligible to receive pregnancy related and emergency services through the federal Medicaid program. DHCS is projecting a 1.4% increase in member months as a result of enrolling those who are over 49 years of age and an increase of 5.48% as a result of enrolling those who are between 26 and 49. DHCS has updated the projected member months in Projected Years 1 through 5 to reflect these changes.

*To account for non-citizens with unsatisfactory immigration statute over 49 years of age, DHCS increased the member months reported in quarter 2 by .93% (1.4%*2/3) and increased the member months in all subsequent quarters by 1.4%. To account for non-citizens with unsatisfactory immigration status between 26 and 49 years of age, DHCS increased the member months reported in quarters 9 through 20 by 5.38%.*

d. **X** Required] Explain any other variance in eligible member months from BY/R1 to P2:

DHCS Response

MCMC and Dental MC: *In P2, to align with the transition of CCI to a statewide aligned enrollment structure, the State is ending the CCI Dual (non-CMC) and CMC eligibility groups. Members in these eligibility groups are projected to shift to the SPD Dual eligibility group.*

SMHS and DMC-ODS: *No other changes***.**

e. **X** [Required] Specify whether the BY/R1/R2 is a State fiscal year (SFY), Federal fiscal year (FFY), or other period:

DHCS Response

MCMC, Dental MC, SMHS, and DMC-ODS: *BY/R1/R2 are SFY. BY reflects SFY 2018-19 (June 1, 2018 through September 30, 2019)*.

F. Appendix D2.S - Services in Actual Waiver Cost

For Initial Waivers: *[NOT APPLICABLE]*

a.___ [Required] Explain the exclusion of any services from the cost-effectiveness analysis. For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account.

For Conversion or Renewal Waivers:

a. **X** [Required] Explain if different services are included in the Actual Waiver Cost from the previous period in **Appendix D3** than for the upcoming waiver period in **Appendix D5**. Explain the differences here and how the adjustments were made on **Appendix D5**:

DHCS Response

The previous 1915(b) waiver only included mental health services. This renewal waiver includes:

- *most components of the physical health and dental managed care delivery systems, which transitioned from the 1115 demonstration authority to the 1915(b) waiver; and*
- *substance use disorder services provided through DMC-ODS counties, which also transitioned from 1115 demonstration authority to the 1915(b) waiver.*

MCMC and Dental MC: *The Actual Waiver Cost in Appendix D3 represents expenditures under the 1115 demonstration that, with a few*

exceptions, align with services and populations under this renewal waiver. To address these exceptions, notably the carve-out or carve-in of certain services in P1 or P2, DHCS applied program adjustments to the P1 and P2 projected expenditures as described in Section D.I.J.b.2.vi.D below.[26]

SMHS and DMC-ODS: *The State Plan costs reported in Appendix D5 for the base year includes expenditures for mental health services assigned to the 1915(b) waiver and expenditures for substance use disorder services assigned to the DMC-ODS 1115 demonstration reported on the CMS 64 for quarters ending September 30, 2018, December 31, 2018, March 31, 2019, and June 30, 2019. DHCS also included a program adjustment in Prospective Year 2 to account for 10 new counties starting to provide substance use disorder services through the 1915(b) PIHP delivery system. DHCS included costs for lab or radiology in the retrospective state plan cost for SMHS. DHCS also included costs for the following specialty mental health impacted services: Psychiatric inpatient hospital services, other practitioners, physicians, pharmacy, long term care, and mental health services provided in FQHCs.*

Service categories that have checkmarks in both Columns H and I reflect certain services in this category are responsibility of the psychiatric inpatient hospital services (either in the SMHS or DMC-ODS delivery system) as well as certain services in this category that are impacted by the psychiatric inpatient hospital services (either in the SMHS or DMC-ODS delivery system)

b. **X** [Required] Explain the exclusion of any services from the cost-effectiveness analysis. For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account:

DHCS Response

MCMC and Dental MC: *DHCS has excluded from the cost-effectiveness analysis the following: 1) services delivered through the Medi-Cal managed care delivery system but not included in this waiver, such as*

[26] Effective January 1, 2022, pharmacy and related benefits (listed in Attachment III) that are billed by a pharmacy on a pharmacy claim, including covered outpatient drugs and physician administered drugs, medical supplies and enteral nutritional products, as described in the Medi-Cal Rx All Plan Letter (APL 20-020) will be carved out of Medi-Cal managed care capitated benefits. Pharmacy and related benefits that are billed on medical and institutional claims, including physician administered drugs, other outpatient drugs, legend, non-legend and specialty drugs, medical supplies and enteral nutritional products, that are not carved-out to Medi-Cal Rx as discussed above, and further described in Medi-Cal Rx All Plan Letter (APL 20-020), will remain carved in to Medi-Cal managed care capitated benefits.

Community-Based Adult Services (included in 1115 demonstration authority) and services for Out-of-State Former Foster Care Youth; and 2) services carved out of the Medi-Cal managed care delivery system, such as In-Home Supportive Services and 1915(c) waiver HCBS services.

SMHS and DMC-ODS: *All Medi-Cal mental health service costs and substance use disorder service costs, except for the following costs, are accounted for in this waiver: 1) the cost of substance use disorder services provided by prepaid inpatient health plans (PIHP) in an Institution for Mental Disease (IMD), and 2) the cost of specialty mental health and substance use disorder services provided by PIHPs to Medi-Cal beneficiaries with unsatisfactory immigration status excluding pregnancy related allowable claims. The cost of state plan substance use disorder services provided to beneficiaries residing in counties that do not provide substance use disorder services through a PIHP delivery system are excluded from this waiver. DHCS included a program adjustment in Prospective Year 2 to account for the cost of 10 new counties to begin providing substance use disorder services through a PIHP delivery system. The cost of substance use disorder services provided to beneficiaries in an IMD and the cost of substance use disorder services provided to AI/AN beneficiaries is separately accounted for in the State's 1115 demonstration and it is not included in the State's 1915(b) renewal waiver. California included a program adjustment in Prospective Year 1 to remove the cost of specialty mental health and substance use disorder services provided to Medi-Cal beneficiaries with unsatisfactory immigration status excluding pregnancy related allowable claims.*

G. Appendix D2.A - Administration in Actual Waiver Cost

[Required] The State allocated administrative costs between the Fee-for-service and managed care program depending upon the program structure. *Note: initial programs will enter only FFS costs in the BY. Renewal and Conversion waivers will enter all waiver and FFS administrative costs in the R1 and R2 or BY.*

For Initial Waivers: *[NOT APPLICABLE]*

a. For an initial waiver, please document the amount of savings that will be accrued in the State Plan services. Savings under the waiver must be great enough to pay for the waiver administration costs in addition to those costs in FFS. Please state the aggregate budgeted amount projected to be spent on each additional service in the upcoming waiver period in the chart below. **Appendix D5** should reflect any savings to be accrued as well as any additional administration expected. The savings should at least offset the administration.

Additional Administration Expense	Savings projected in	Inflation projected	Amount projected to be spent in Prospective Period

	State Plan Services		
(Service Example: Actuary, Independent Assessment, EQRO, Enrollment Broker- See attached documentation for justification of savings.)	*$54,264 savings or .03 PMPM*	*9.97% or $5,411*	*$59,675 or .03 PMPM P1* *$62,488 or .03 PMPM P2*
Total	*Appendix D5 should reflect this.*		*Appendix D5 should reflect this.*

The allocation method for either initial or renewal waivers is explained below:

a.___ The State allocates the administrative costs to the managed care program based upon the number of waiver enrollees as a percentage of total Medicaid enrollees. *Note: this is appropriate for MCO/PCCM programs.*

b.___ The State allocates administrative costs based upon the program cost as a percentage of the total Medicaid budget. It would not be appropriate to allocate the administrative cost of a mental health program based upon the percentage of enrollees enrolled. *Note: this is appropriate for statewide PIHP/PAHP programs.*

c. **X** Other (Please explain).

DHCS Response

MCMC and Dental MC: *DHCS is directly identifying administrative costs associated with this waiver. Reported amounts are based on actual or estimated program administration costs for State staff, related overhead/support costs, and administrative contractors (e.g., actuarial, Information Technology) dedicated to the Medi-Cal managed care delivery system. The EQRO costs included in the MCMC and Dental MC cost effectiveness calculations are specific to these delivery systems and do not overlap with the SMHS and DMC-ODS delivery systems.*

SMHS and DMC-ODS: *DHCS directly identifies DHCS' costs associated with this waiver. DHCS costs are based on actual percentages of time spent by State staff on this waiver. County-operated PIHPs Administration costs for: i) PIHP administration; ii) quality assurance and utilization review (QA-UR); and iii) Medi-Cal Administrative Activities (MAA), are also included as part of the State administrative costs. The EQRO costs included in the SMHS and DMC-ODS cost effectiveness calculations are specific to these delivery systems and do not overlap with the MCMC and Dental MC delivery systems.*

H. Appendix D3 – Actual Waiver Cost

a.__ The State is requesting a 1915(b)(3) waiver in **Section A.I.A.1.c** and will be providing non-state plan medical services. The State will be spending a portion of its waiver savings for additional services under the waiver. *(Applies to DMC-ODS)*

For an initial waiver, in the chart below, please document the amount of savings that will be accrued in the State Plan services. The amount of savings that will be spent on 1915(b)(3) services must be reflected on **Column T of Appendix D5** in the initial spreadsheet Appendices. Please include a justification of the amount of savings expected and the cost of the 1915(b)(3) services. Please state the aggregate budgeted amount projected to be spent on each additional service in the upcoming waiver period in the chart below. This amount should be reflected in the State's Waiver Cost Projection for P1 and P2 on **Column W in Appendix D5**.

Chart: Initial Waiver State Specific 1915(b)(3) Service Expenses and Projections *[NOT APPLICABLE]*

1915(b)(3) Service	Savings ~~projected~~ accrued in State Plan Services	Inflation projected	Amount projected to be spent in Prospective Period
Total	***(PMPM in Appendix D5 Column T x projected member months should correspond)***		**(PMPM in Appendix D5 Column W x projected member months should correspond)**

For a renewal or conversion waiver, in the chart below, please state the actual amount spent on each 1915(b)(3) service in the retrospective waiver period. This amount must be built into the State's Actual Waiver Cost for R1 and R2 (BY for Conversion) on **Column H in Appendix D3**. Please state the aggregate amount of 1915(b)(3) savings budgeted for each additional service in the upcoming waiver period in the chart below. This amount must be built into the State's Waiver Cost Projection for P1 and P2 on **Column W in Appendix D5**.

Chart: Renewal/Conversion Waiver State Specific 1915(b)(3) Service Expenses and Projections *[NOT APPLICABLE]*

1915(b)(3) Service	Amount Spent in Retrospective Period	Inflation projected	Amount projected to be spent in Prospective Period
(Service Example: 1915(b)(3) step-down nursing care services financed from savings from inpatient hospital care. See attached documentation for justification of savings.)	*$1,751,500 or $.97 PMPM R1* *$1,959,150 or $1.04 PMPM R2 or BY in Conversion*	*8.6% or $169,245*	*$2,128,395 or 1.07 PMPM in P1* *$2,291,216 or 1.10 PMPM in P2*
Total	**(PMPM in Appendix D3 Column H x member months should correspond)**		**(PMPM in Appendix D5 Column W x projected member months should correspond)**

b. X The State is including voluntary populations in the waiver *(Applies to MCMC, Dental MC)*.

Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations:

DHCS Response

MCMC and Dental MC: *Voluntary populations in the waiver were voluntary prior to the waiver including the base year. DHCS has no knowledge of or reason to anticipate material changes in selection between the base year and years under the waiver. Examples of voluntary populations include: 1) beneficiaries in San Benito County choose between a single commercial plan and FFS, and enrollment in managed care is voluntary; 2) Foster Youth in non-COHS counties; and 3) dually eligible beneficiaries except in COHS and CCI counties in P1 only (January 1, 2022 through December 31, 2022), after which they will be mandatorily enrolled in managed care statewide.*

c.___ Capitated portion of the waiver only -- Reinsurance or Stop/Loss Coverage: Please note how the State will be providing or requiring reinsurance or stop/loss coverage as required under the regulation. States may require MCOs/PIHPs/PAHPs to purchase reinsurance. Similarly, States may provide stop-loss coverage to MCOs/PIHPs/PAHPs when MCOs/PIHPs/PAHPs exceed certain payment thresholds for individual enrollees. Stop loss provisions usually set limits on maximum days of coverage or number of services for which the MCO/PIHP/PAHP will be responsible. If the State plans to provide stop/loss coverage, a description is required. The State must document the probability of incurring costs in excess of the stop/loss level and the frequency of such occurrence based on FFS experience. The expenses per capita (also known as the stoploss premium amount) should be deducted from the capitation year projected costs. In the initial application, the effect should be neutral. In the renewal report, the actual reinsurance cost and claims cost should be reported in Actual Waiver Cost.

Basis and Method:

1.___ The State does not provide stop/loss protection for MCOs/PIHPs/PAHPs, but requires MCOs/PIHPs/PAHPs to purchase reinsurance coverage privately. No adjustment was necessary.

2.___ The State provides stop/loss protection (please describe):

DHCS Response

This question appears out-dated. Per 42 CFR § 438.6(b), the State is not required to provide or require reinsurance or stop-loss.

d.___ Incentive/bonus/enhanced Payments for both Capitated and fee-for-service Programs:

1.___ [For the capitated portion of the waiver] the total payments under a capitated contract include any incentives the State provides in addition to capitated payments under the waiver program. The costs associated with any bonus arrangements must be accounted for in the capitated costs **(Column D of Appendix D3 Actual Waiver Cost).** Regular State Plan service capitated adjustments would apply.

i. Document the criteria for awarding the incentive payments.
ii. Document the method for calculating incentives/bonuses, and
iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs do not exceed the Waiver Cost Projection.

2.____ For the fee-for-service portion of the waiver, all fee-for-service must be accounted for in the fee-for-service incentive costs **(Column G of Appendix D3 Actual Waiver Cost).** For PCCM providers, the amount listed should match information provided in **D.I.D Reimbursement of Providers**. Any adjustments applied would need to meet the special criteria for fee-for-service incentives if the State elects to provide incentive payments in addition to management fees under the waiver program **(See D.I.I.e and D.I.J.e)**

i. Document the criteria for awarding the incentive payments.
ii. Document the method for calculating incentives/bonuses, and
iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs/PCCMs do not exceed the Waiver Cost Projection.

Current Initial Waiver Adjustments in the preprint

I. Appendix D4 – Initial Waiver – Adjustments in the Projection OR Conversion Waiver for DOS within DOP *[NOT APPLICABLE]*

Initial Waiver Cost Projection & Adjustments (If this is a Conversion or Renewal waiver for DOP, skip to J. Conversion or Renewal Waiver Cost Projection and Adjustments):

States may need to make certain adjustments to the Base Year in order to accurately reflect the waiver program in P1 and P2. If the State has made an adjustment to its Base Year, the State should note the adjustment and its location in Appendix D4, and include information on the basis and method used in this section of the preprint. Where noted, certain adjustments should be mathematically accounted for in Appendix D5.

The following adjustments are appropriate for initial waivers. Any adjustments that are required are indicated as such.

a. **State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The BY data already includes the actual Medicaid cost changes to date for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from BY to the end of the waiver (P2). Trend adjustments may be service-specific. The adjustments may be expressed as percentage factors. Some states calculate utilization and cost increases separately, while other states calculate a single trend rate encompassing both utilization and cost increases. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **This adjustment must be mutually exclusive of programmatic/policy/pricing**

changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.

1.___ [Required, if the State's BY is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period *(i.e., trending from 1999 to present)* The actual trend rate used is: _____. Please document how that trend was calculated:

2.___ [Required, to trend BY to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated ratesetting regulations) *(i.e., trending from present into the future)*.

i. ____ State historical cost increases. Please indicate the years on which the rates are based: base years_____ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

ii.____National or regional factors that are predictive of this waiver's future costs. Please indicate the services and indicators used_____. Please indicate how this factor was determined to be predictive of this waiver's future costs. Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

3.____The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between the BY and the beginning of the P1 and between years P1 and P2.

i. Please indicate the years on which the utilization rate was based (if calculated separately only).

ii. Please document how the utilization did not duplicate separate cost increase trends.

b. __ **State Plan Services Programmatic/Policy/Pricing Change Adjustment:** This adjustment should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. Adjustments to the BY data are typically for changes that occur after the BY (or after the collection of the BY data) and/or during P1 and P2 that affect the overall Medicaid program. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in

hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA*.

Others:

- Additional State Plan Services (+)
- Reductions in State Plan Services (-)
- Legislative or Court Mandated Changes to the Program Structure or fee schedule not accounted for in cost increases or pricing (+/-)

1.___ The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.

2.___ An adjustment was necessary. The adjustment(s) is(are) listed and described below:

i.__ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods. For each change, please report the following:

A.____ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____ Determine adjustment for Medicare Part D dual eligibles.

E.____ Other (please describe):

ii.__ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.

iii.__ Changes brought about by legal action (please describe):
For each change, please report the following:

A.____ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____ Other (please describe):

iv.__ Changes in legislation (please describe):
For each change, please report the following:

A.____ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____ Other (please describe):

v.__ Other (please describe):

A.____ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____ Other (please describe):

c.___ **Administrative Cost Adjustment*:** The administrative expense factor in the initial waiver is based on the administrative costs for the eligible population participating in the waiver for fee-for-service. Examples of these costs include per claim claims processing costs, per record PRO review costs, and Surveillance and Utilization Review System (SURS) costs. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program.* If the State is changing the administration in the fee-for-service program then the State needs to estimate the impact of that adjustment.

1.___ No adjustment was necessary and no change is anticipated.

2.___ An administrative adjustment was made.

i.___ FFS administrative functions will change in the period between the beginning of P1 and the end of P2. Please describe:

A.____ Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).

B.____ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).

C.____ Other (please describe):

ii.___ FFS cost increases were accounted for.

A.____ Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).

B.____ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).

C.____ Other (please describe):

iii.___ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State

administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate. Please document both trend rates and indicate which trend rate was used.

A. Actual State Administration costs trended forward at the State historical administration trend rate. Please indicate the years on which the rates are based: base years_____ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase.

B. Actual State Administration costs trended forward at the State Plan Service Trend rate. Please indicate the State Plan Service trend rate from **Section D.I.I.a**. above _____.

* For Combination Capitated and PCCM Waivers: If the capitated rates are adjusted by the amount of administration payments, then the PCCM Actual Waiver Cost must be calculated less the administration amount. For additional information, please see Special Note at end of this section.

d. 1915(b)(3) Adjustment: The State must document the amount of State Plan Savings that will be used to provide additional 1915(b)(3) services in **Section D.I.H.a** above. The Base Year already includes the actual trend for the State Plan services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the Base Year and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.

1.___ [Required, if the State's BY is more than 3 months prior to the beginning of P1 to trend BY to P1] The State is using the actual State historical trend to project past data to the current time period *(i.e., trending from 1999 to present).* The actual documented trend is: _____. Please provide documentation.

2.___ [Required, when the State's BY is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future *(i.e., trending from present into the future)*, the State must use the State's trend for State Plan Services.

i. State Plan Service trend

A. Please indicate the State Plan Service trend rate from **Section D.I.I.a**. above _____.

e. **Incentives (not in capitated payment) Trend Adjustment:** If the State marked **Section D.I.H.d** , then this adjustment reports trend for that factor. Trend is limited to the rate for State Plan services.

1. List the State Plan trend rate by MEG from **Section D.I.I.a**._____
2. List the Incentive trend rate by MEG if different from **Section D.I.I.a** _____
3. Explain any differences:

f. **Graduate Medical Education (GME) Adjustment**: 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments for managed care participant utilization in the capitation rates. However, GME payments on behalf of managed care waiver participants must be included in cost-effectiveness calculations.

1.___ We assure CMS that GME payments are included from base year data.
2.___ We assure CMS that GME payments are included from the base year data using an adjustment. (Please describe adjustment.)
3.___ Other (please describe):

If GME rates or the GME payment method has changed since the Base Year data was completed, the Base Year data should be adjusted to reflect this change and the State needs to estimate the impact of that adjustment and account for it in **Appendix D5**.

1.___ GME adjustment was made.
   i.___ GME rates or payment method changed in the period between the end of the BY and the beginning of P1 (please describe).
   ii.___ GME rates or payment method is projected to change in the period between the beginning of P1 and the end of P2 (please describe).
2.___ No adjustment was necessary and no change is anticipated.

Method:

1.___ Determine GME adjustment based upon a newly approved State Plan Amendment (SPA).
2.___ Determine GME adjustment based on a pending SPA.
3.___ Determine GME adjustment based on currently approved GME SPA.
4.___ Other (please describe):

g. **Payments / Recoupments not Processed through MMIS Adjustment:** Any payments or recoupments for covered Medicaid State Plan services included in the waiver but processed outside of the MMIS system should be included in the Waiver Cost Projection. Any adjustments that would appear on the CMS-64.9 Waiver form should be reported and adjusted here. Any adjustments that would appear on the CMS summary form (line 9) would not be put into the waiver cost-effectiveness (e.g., TPL, probate, fraud and abuse). Any payments or recoupments made should be accounted for in **Appendix D5.**

1.___ Payments outside of the MMIS were made. Those payments include (please describe):
2.___ Recoupments outside of the MMIS were made. Those recoupments include (please describe):
3.___ The State had no recoupments/payments outside of the MMIS.

h. Copayments Adjustment: This adjustment accounts for any copayments that are collected under the FFS program but will not be collected in the waiver program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program.

Basis and Method:

1.___ Claims data used for Waiver Cost Projection development already included copayments and no adjustment was necessary.
2.___ State added estimated amounts of copayments for these services in FFS that were not in the capitated program. Please account for this adjustment in Appendix D5.
3.___ The State has not to made an adjustment because the same copayments are collected in managed care and FFS.
4.___ Other (please describe):

If the State's FFS copayment structure has changed in the period between the end of the BY and the beginning of P1, the State needs to estimate the impact of this change adjustment.

1.___ No adjustment was necessary and no change is anticipated.
2___ The copayment structure changed in the period between the end of the BY and the beginning of P1. Please account for this adjustment in Appendix D5.

Method:

1.___ Determine copayment adjustment based upon a newly approved State Plan Amendment (SPA).
2.___ Determine copayment adjustment based on pending SPA.
3.___ Determine copayment adjustment based on currently approved copayment SPA.
4.___ Other (please describe):

i. Third Party Liability (TPL) Adjustment: This adjustment should be used only if the State is converting from fee-for-service to capitated managed care, and will delegate the collection and retention of TPL payments for post-pay recoveries to the MCO/PIHP/PAHP. If the MCO/PIHP/PAHP will collect and keep TPL, then the Base Year costs should be reduced by the amount to be collected.

Basis and method:

1.___No adjustment was necessary
2.___Base Year costs were cut with post-pay recoveries already deducted from the database.
3.___State collects TPL on behalf of MCO/PIHP/PAHP enrollees

4.___The State made this adjustment:*

i.___ Post-pay recoveries were estimated and the base year costs were reduced by the amount of TPL to be collected by MCOs/PIHPs/PAHPs. Please account for this adjustment in **Appendix D5.**

ii.___ Other (please describe):

j. Pharmacy Rebate Factor Adjustment : Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the fee-for-service or capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.

Basis and Method:

1.___ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population ***which includes accounting for Part D dual eligibles***. Please account for this adjustment in **Appendix D5**.

2.___ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS ***or Part D for the dual eligibles***.

3.___ Other (please describe):

k. Disproportionate Share Hospital (DSH) Adjustment: Section 4721 of the BBA specifies that DSH payments must be made solely to hospitals and not to MCOs/PIHPs/PAHPs. Section 4721(c) permits an exemption to the direct DSH payment for a limited number of States. If this exemption applies to the State, please identify and describe under "Other" including the supporting documentation. Unless the exemption in Section 4721(c) applies or the State has a FFS-only waiver (e.g., selective contracting waiver for hospital services where DSH is specifically included), DSH payments are not to be included in cost-effectiveness calculations.

1.___ We assure CMS that DSH payments are excluded from base year data.

2.___ We assure CMS that DSH payments are excluded from the base year data using an adjustment.

3.___ Other (please describe):

l. Population Biased Selection Adjustment (Required for programs with Voluntary Enrollment): Cost-effectiveness calculations for waiver programs with voluntary populations must include an analysis of the population that can be

expected to enroll in the waiver. If the State finds that the population most likely to enroll in the waiver differs significantly from the population that will voluntarily remain in FFS, the Base Year costs must be adjusted to reflect this.

1.___ This adjustment is not necessary as there are no voluntary populations in the waiver program.

2.___ This adjustment was made:

a. ___Potential Selection bias was measured in the following manner:

b.___The base year costs were adjusted in the following manner:

m. FQHC and RHC Cost-Settlement Adjustment: Base Year costs should not include cost-settlement or supplemental payments made to FQHCs/RHCs. The Base Year costs should reflect fee-for-service payments for services provided at these sites, which will be built into the capitated rates.

1.___ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the Base Year costs. Payments for services provided at FQHCs/RHCs are reflected in the following manner:

2.___ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the base year data using an adjustment.

3.___ ***We assure CMS that Medicare Part D coverage has been accounted for in the FQHC/RHC adjustment.***

4.___ Other (please describe):

Special Note section:

Waiver Cost Projection Reporting: Special note for new capitated programs: The State is implementing the first year of a new capitated program (converting from fee-for-service reimbursement). The first year that the State implements a capitated program, the State will be making capitated payments for future services while it is reimbursing FFS claims from retrospective periods. This will cause State expenditures in the initial period to be much higher than usual. In order to adjust for this double payment, the State should not use the first quarter of costs (immediately following implementation) from the CMS-64 to calculate future Waiver Cost Projections, unless the State can distinguish and exclude dates of services prior to the implementation of the capitated program.

a.___ The State has excluded the first quarter of costs of the CMS-64 from the cost-effectiveness calculations and is basing the cost-effectiveness projections on the remaining quarters of data.

b.___ The State has included the first quarter of costs in the CMS-64 and excluded claims for dates of services prior to the implementation of the capitated program.

[NOT APPLICABLE] **Special Note for initial combined waivers (Capitated and PCCM) only:**

Adjustments Unique to the Combined Capitated and PCCM Cost-effectiveness Calculations -- Some adjustments to the Waiver Cost Projection are applicable only to the capitated program. When these adjustments are taken, there will need to be an

offsetting adjustment to the PCCM Base year Costs in order to make the PCCM costs comparable to the Waiver Cost Projection. **In other words, because we are creating a single combined Waiver Cost Projection applicable to the PCCM and capitated waiver portions of the waiver, offsetting adjustments (positive and/or negative) need to be made to the PCCM Actual Waiver Cost for certain *capitated-only* adjustments.** When an offsetting adjustment is made, please note and include an explanation and your calculations. The most common offsetting adjustment is noted in the chart below and indicated with an asterisk (*) in the preprint.

Adjustment	Capitated Program	PCCM Program
Administrative Adjustment	The Capitated Waiver Cost Projection includes an administrative cost adjustment. That adjustment is added into the combined Waiver Cost Projection adjustment. (This in effect adds an amount for administration to the Waiver Cost Projection for both the PCCM and Capitated program. You must now remove the impermissible costs from the PCCM With Waiver Calculations -- See the next column)	The PCCM Actual Waiver Cost must include an exact offsetting addition of the amount of the PMPM Waiver Cost Projection adjustment. (While this may seem counter-intuitive, adding the exact amount to the PCCM PMPM Actual Waiver Cost will subtract out of the equation: PMPM Waiver Cost Projection – PMPM Actual Waiver Cost = PMPM Cost-effectiveness).

n. **Incomplete Data Adjustment (DOS within DOP only)**– The State must adjust base period data to account for incomplete data. When fee-for-service data is summarized by date of service (DOS), data for a particular period of time is usually incomplete until a year or more after the end of the period. In order to use recent DOS data, the State must calculate an estimate of the services ultimate value after all claims have been reported . Such incomplete data adjustments are referred to in different ways, including “lag factors,” “incurred but not reported (IBNR) factors,” or incurring factors. If date of payment (DOP) data is used, completion factors are not needed, but projections are complicated by the fact that payments are related to services performed in various former periods. *Documentation of assumptions and estimates is required for this adjustment.*

1.___ Using the special DOS spreadsheets, the State is estimating DOS within DOP. Incomplete data adjustments are reflected in the following manner on **Appendix D5** for services to be complete and on **Appendix D7** to create a 12-month DOS within DOP projection:

2.___ The State is using Date of Payment only for cost-effectiveness – no adjustment is necessary.

3.___ Other (please describe):

o. *[NOT APPLICABLE]* **PCCM Case Management Fees (Initial PCCM waivers only) –** The State must add the case management fees that will be claimed by the State under new PCCM waivers. There should be sufficient savings under the waiver to offset these fees. The new PCCM case management fees will be accounted for with an adjustment on **Appendix D5.**

1.___ This adjustment is not necessary as this is not an initial PCCM waiver in the waiver program.

2.___ This adjustment was made in the following manner:

p. **Other adjustments**: Federal law, regulation, or policy change: If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.

- Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
  - ♦ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
  - ♦ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.

1. No adjustment was made.
2. This adjustment was made (Please describe) This adjustment must be mathematically accounted for in **Appendix D5**.

J. Appendix D4 – Conversion or Renewal Waiver Cost Projection and Adjustments.

If this is an Initial waiver submission, skip this section: States may need to make certain adjustments to the Waiver Cost Projection in order to accurately reflect the waiver program. If the State has made an adjustment to its Waiver Cost Projection, the State should note the adjustment and its location in **Appendix D4**, and include information on the basis and method, and mathematically account for the adjustment in **Appendix D5**.

CMS should examine the Actual Waiver Costs to ensure that if the State did not implement a programmatic adjustment built into the previous Waiver Cost Projection, that the State did not expend funds associated with the adjustment that was not implemented.

If the State implements a one-time only provision in its managed care program (typically administrative costs), the State should not reflect the adjustment in a permanent

manner. CMS should examine future Waiver Cost Projections to ensure one-time-only adjustments are not permanently incorporated into the projections.

DHCS Response

DHCS anticipates additions or revisions to adjustments as we advance in implementation of CalAIM initiatives (e.g., behavioral health payment reform), expand on state budget initiatives, and receive further Legislative direction. DHCS will engage with CMS to amend these adjustments and cost effectiveness calculations as necessary.

a. X State Plan Services Trend Adjustment – the State must trend the data forward to reflect cost and utilization increases. The R1 and R2 (BY for conversion) data already include the actual Medicaid cost changes for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from R2 (BY for conversion) to the end of the waiver (P2). Trend adjustments may be service-specific and expressed as percentage factors. Some states calculate utilization and cost separately, while other states calculate a single trend rate. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**

1. **X** [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period *(i.e., trending from 1999 to present)*

   The actual trend rate used is:

   DHCS Response

   MCMC and Dental MC: *4.95 percent annually*

   SMHS and DMC-ODS: *6.3 percent annually (applies to SMHS, DMC-ODS)*.

   Please document how that trend was calculated:

   DHCS Response

   MCMC and Dental MC: *The State's actuaries reviewed the Medi-Cal managed care program experience trend with a focus on the major rate categories over a four-year period (CY 2016 to CY 2019) and the national per capita trend for the four major Medicaid categories of aid (Child, Adult,*

ACE OE, and SPD) as projected by CMS through CY 2026 in its most recent 2018 actuarial report (https://www.cms.gov/files/document/2018-report.pdf). Based on the review and internal discussion, the actuaries recommended the State use a single PMPM trend of 4.95 percent across all eligibility groups. In developing this single MEG-wide PMPM trend, the actuaries considered the program experience, national PMPM trend for Medicaid populations, CY 2021 capitation rate development trend assumptions, and consideration given the length of the projection period (5-year waiver period). For P1, the State applied a compounded trend factor of 18.42 percent, calculated by compounding the 4.95 percent annual trend over 3.5 years from the midpoint of the base year (January 1, 2019) to the midpoint of P1 (July 1, 2022).

SMHS and DMC-ODS: *The retrospective year of data includes actual expenditures reported on the CMS 64 for quarters ending September 30, 2018, December 31, 2018, March 31, 2019, and June 30, 2019 for mental health services assigned to the 1915(b) waiver (CA17.R09) and substance use disorder services assigned to the DMC-ODS 1115 demonstration. DHCS reduced these actual expenditures by the amount it identified as costs incurred to provide services to beneficiaries with unsatisfactory immigration status excluding pregnancy related allowable claims; the amount it spent on substance use disorder services provided to beneficiaries in an IMD; and the amount it spent on substance use disorder services provided to American Indian and Alaskan Native beneficiaries. DHCS trended the result to Prospective Year 1 using the percentage change in the Home Health Agency Market Basket Index to account for inflation. The State Plan Inflation Adjustment for P2 through P5 is equal to the percentage change in the Home Health Agency Market Basket Index from the first quarter of the base year to the first quarter of the projected year.*

2. **X** [Required, to trend BY/R2 to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated ratesetting regulations) *(i.e., trending from present into the future)*.
   i. **X** State historical cost increases *(Applies to MCMC, Dental MC)*.

      Please indicate the years on which the rates are based: ***CY 2016 through CY 2019***

      In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). ***The mathematical method used is year over year exponential smoothing.***

Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM. ***Yes, the trend includes both the utilization trend (changes in technology, practice patterns, and units of services including service mix changes) component and the unit cost trend (price increase) component.***

ii. **X** National or regional factors that are predictive of this waiver's future costs. *(Applies to MCMC, Dental MC, SMHS, DMC-ODS)*

Please indicate the services and indicators used:

DHCS Response

MCMC and Dental MC: *A five-year annualized prospective PMPM trend (FY2021 to FY2026) as projected by CMS for each major category of aid (Aged, Disabled, Child, Adults, and Expansion Adults) in its 2018 Actuarial Report On The Financial Outlook For Medicaid. The categories of aid encompass a comprehensive level of Medicaid services.*

SMHS and DMC-ODS: *Home Health Agency Market Basket Index*

In addition, please indicate how this factor was determined to be predictive of this waiver's future costs:

DHCS Response

MCMC and Dental MC: *The prospective PMPM trend as projected by CMS for Medicaid on a national basis is considered to be an excellent indicator of future trends over a similar five-year projection period for this waiver's future costs given the large program size and similar types of covered populations and services.*

SMHS and DMC-ODS: *DHCS has found the Home Health Agency Market Basket Index produced by CMS as the most relevant and available predictor of future costs and is used in current payment processes for the SMHS and DMC-ODS delivery systems. CMS uses the Office of the Actuary (OACT) staff on a variety of market basket topics, including index development and construction, theoretical update frameworks, and wage studies which produce actuarially sound indexes.*

Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as

changes in technology, practice patterns, and/or units of service PMPM.

DHCS Response

MCMC and Dental MC: *Yes, the trend includes both the utilization trend (changes in technology, practice patterns, and units of services including service mix changes) component and the unit cost trend (price increase) component.*

SMHS and DMC-ODS: *The PMPM costs per MEG are trended for P1, P2, P3, P4 and P5 utilizing the percentage change in the CMS' Home Health Agency Market Basket (HHAMB) Index for each PY.*

3. **X** The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between R2 and P1 and between years P1 and P2. *(Applies to SMHS, DMC-ODS)*

   i. Please indicate the years on which the utilization rate was based (if calculated separately only).

   DHCS Response

   SMHS and DMC-ODS: *DHCS estimated that it would spend an additional $11 million on SUD services provided through a PIHP delivery system to beneficiaries in 10 additional counties in prospective year. DHCS estimated $11 million based upon State Fiscal Year 2019-20 actual expenditures in counties that currently provide SUD services through a PIHP delivery system with populations similar to the 10 counties projected to begin providing SUD services through a PIHP delivery system.*

   ii. Please document how the utilization did not duplicate separate cost increase trends.

   DHCS Response

   SMHS and DMC-ODS: *DHCS's estimated cost increase due to change in utilization does not duplicate the inflation cost increase described above. DHCS used the percentage change in the HHAMB index from P1 (CY 2022) to P2 (CY 2023) to estimate the increase in the PMPM due to inflation. California separately*

*calculated the percentage change in the PMPM in P1 as the ratio of total estimated increased costs for the 10 additional counties using SFY 2019-20 claims data to the R2 costs increased by the percentage change in the HHAMB index from 2018 Q2 to 2019 Q 2 ($4,130,795,712*1.0256).*

b. **X** **State Plan Services Programmatic/Policy/Pricing Change Adjustment:** These adjustments should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA*. The R2 data was adjusted for changes that will occur after the R2 (BY for conversion) and during P1 and P2 that affect the overall Medicaid program.
(Applies to MCMC, Dental MC, SMHS, DMC-ODS)

Others:

- Additional State Plan Services (+)
- Reductions in State Plan Services (-)
- Legislative or Court Mandated Changes to the Program Structure or fee schedule not accounted for in Cost increase or pricing (+/-)
- Graduate Medical Education (GME) Changes - This adjustment accounts for **changes** in any GME payments in the program. 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments from the capitation rates. However, GME payments must be included in cost-effectiveness calculations.
- Copayment Changes - This adjustment accounts for changes from R2 to P1 in any copayments that are collected under the FFS program, but not collected in the MCO/PIHP/PAHP capitated program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program. If the State is changing the copayments in the FFS program then the State needs to estimate the impact of that adjustment.

1.___ The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.

2. **X** An adjustment was necessary and is listed and described below:
(Applies to MCMC, Dental MC, SMHS, DMC-ODS)

i.__ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods. For each change, please report the following:
A.___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
B.___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
C.___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
D.___ Determine adjustment for Medicare Part D dual eligible,
E.___ Other (please describe):

ii.__ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.

iii.__ The adjustment is a one-time only adjustment that should be deducted out of subsequent waiver renewal projections (i.e., start-up costs). Please explain:

iv.__ Changes brought about by legal action (please describe):
For each change, please report the following:
A.___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
B.___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
C.___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
D.___ Other (please describe):

v.__ Changes in legislation (please describe):
For each change, please report the following:
A.___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
B.___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
C.___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
D.___ Other (please describe):

vi. **X** Other (please describe):

A.___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D. **X** Other (please describe):

DHCS Response

MCMC and Dental MC: *The State applied the following programmatic adjustments:*

1) *Reducing P1 and P2 projected expenditures for the carve-out (from Medi-Cal managed care) of specialty mental health services for a subset of beneficiaries in Sacramento County and Solano County, effective July 1, 2022. Note, these services and populations are included in this waiver under the behavioral health eligibility groups. The impact of the reduction is $16.7 million distributed across applicable eligibility groups and both projection years.*
2) *Increasing P1 projected expenditures for the carve-in (to Medi-Cal managed care) of dental services in San Mateo County, effective January 1, 2022. The impact of the increase is $10.7 million distributed across applicable eligibility groups.*
3) *Reducing P1 projected expenditures for the carve-out of pharmacy services billed on a pharmacy claim, effective January 1, 2022. The impact of the reduction is $6,904.0 million distributed across applicable eligibility groups. As noted previously, effective January 1, 2022, pharmacy and related benefits (listed in Attachment III) that are billed by a pharmacy on a pharmacy claim, including covered outpatient drugs and physician administered drugs, medical supplies and enteral nutritional products, as described in the Medi-Cal Rx All Plan Letter (APL 20-020) will be carved out of Medi-Cal managed care capitated benefits. Pharmacy and related benefits that are billed on medical and institutional claims, including physician administered drugs, other outpatient drugs, legend, non-legend and specialty drugs, medical supplies and enteral nutritional products, that are not carved-out to Medi-Cal Rx as discussed above, and further described in Medi-Cal Rx All Plan Letter (APL 20-020), will remain carved in to Medi-Cal managed care capitated benefits.*
4) *Reducing projected expenditures to account for the application of two new rate-setting efficiency adjustments in the waiver*

period that were not present in the base year. The impact of the reduction is $203.0 million distributed across applicable eligibility groups.

5) *Increasing P1 projected expenditures for new or expanded covered services such as Major Organ Transplant, Community Health Worker services, Remote Patient Monitoring, Continuous Glucose Monitors, and Dyadic Behavioral Health services, effective January 1, 2022. The impact of the increase is $751.3 million distributed across applicable eligibility groups.*
6) *Increasing P1 projected expenditures for anticipated rate increases associated with addition of Enhanced Care Management as a benefit and the sunset/transition of Whole Person Care Pilots under the CalAIM framework, effective January 1, 2022. The impact of the increase is $565.0 million allocated across applicable eligibility groups.*
7) *Increasing P1 projected expenditures to reflect the ramp-up of the Whole Child Model program, which was not fully phased in during the base year. The impact of the increase is $326.5 million distributed across applicable eligibility groups.*
8) *Adjusting P1, P2, P3, and P4 projected expenditures for new directed payments pursuant to 42 CFR § 438.6(c) that did not exist in the base year, and for increases to directed payments above and beyond annual Consumer Price Index-linked growth. The impact of the adjustment is an increase of $3,509.3 million in P1, $415.0 million in P2, and $75.0 million in P3, and a decrease of $100.0 million in P4, distributed across applicable eligibility groups.*
9) *Increasing P1 projected expenditures for new, time-limited incentive payments pursuant to 42 CFR § 438.6(b) that did not exist in the base year. The impact of the increase is $1,424.8 million distributed across applicable eligibility groups.*
10) *Reducing P2, P3, and P4 projected expenditures for the end of the time-limited incentive payments described above. The impact of the reduction is $38.0 million in P2, $809.3 million in P3, and $577.4 million in P4, distributed across applicable eligibility groups.*
11) *Increasing P2 for the carve-in of long-term care services statewide, effective January 1, 2023. The impact of the increase is $2.817.0 million distributed across applicable eligibility groups.*
12) *Reducing P2 projected expenditures for the end of the current Managed Care Enrollment Tax. The impact of the reduction is $2,656.3 million distributed across applicable eligibility groups.*

The cumulative, weighted-average impact of these adjustments is

-0.95 percent in P1, +0.82 percent in P2, 1.20 percent in P3, and −1.07 percent in P4.

Note, for P2, the State applied a −100.0 percent adjustment to the CCI Dual (non-CMC) and CMC eligibility groups, shifted the member months to the SPD Dual eligibility group, and calculated new, weighted-average P1 PMPMs for State Plan Service Costs and Administrative Service Costs.

SMHS and DMC-ODS: *California included two policy adjustments. In Prospective Year 1, California included a policy adjustment to remove non-pregnancy related services provided to Medi-Cal beneficiaries with unsatisfactory immigration status which were reported on the September 2018, December 2018, March 2019, and June 2019 quarter CMS 64 reports. California removed those expenditures in the September 2020 and December 2020 CMS 64 quarterly reports. In Retrospective Year 2, California included a policy adjustment of .26 percent to account for 10 counties starting to provide substance use disorder services through the PIHP delivery system. The base data calculated the percentage change in the PMPM in P1 as the ratio of total estimated increased costs for the 10 additional counties using SFY 2019-20 claims data to the R2 costs increased by the percentage change in the HHAMB index from 2018 Q2 to 2019 Q 2 ($4,130,795,712*1.0256).*

DHCS added another program and policy adjustment to account for increased costs and utilization for Mental Health Plans and DMC-ODS counties to provide Community-Based Mobile Crisis Intervention Services beginning in January of 2023. DHCS is projecting a PMPM of $1.46 to provide Community-Based Mobile Crisis Intervention Services. DHCS has updated the Policy and Program adjustment percentages in Cells L33 through L39 on Tab D.5 to account for this increase.

c. **X** **Administrative Cost Adjustment:** This adjustment accounts for **changes** in the managed care program. The administrative expense factor in the renewal is based on the administrative costs for the eligible population participating in the waiver for managed care. Examples of these costs include per claim claims processing costs, additional per record PRO review costs, and additional Surveillance and Utilization Review System (SURS) costs; as well as actuarial contracts, consulting, encounter data processing, independent assessments, EQRO reviews, etc. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program.* If the State is changing the administration in the

managed care program, then the State needs to estimate the impact of that adjustment. *(Applies to MCMC, Dental MC, DMC-ODS)*

1.___ No adjustment was necessary, and no change is anticipated.

2.__X__ An administrative adjustment was made. *(Applies to MCMC, Dental MC, DMC-ODS)*

i.___ Administrative functions will change in the period between the beginning of P1 and the end of P2. Please describe:

ii.__X__ Cost increases were accounted for. *(Applies to MCMC, Dental MC, DMC-ODS)*

A.___ Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).

B.___ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).

C.___ State Historical State Administrative Inflation. The actual trend rate used is: _____. Please document how that trend was calculated:

D.__X__ Other (please describe) *(Applies to MCMC, Dental MC, DMC-ODS)*:

DHCS Response

MCMC and Dental MC: *DHCS calculated a 5.39 percent trend rate based on the average of annual salary cost increases over a two-year period (SFY 2017-18 and SFY 2018-19) for program areas within DHCS that are directly responsible for the operation of the Medi-Cal managed care delivery system. For P1, the State applied a compounded trend factor of 20.17 percent, calculated by compounding the 5.39 percent annual trend rate over 3.5 years from the midpoint of the base period (January 1, 2019) to the midpoint of P1 (July 1, 2022).*

DMC-ODS: *DHCS anticipates 10 counties not currently participating in DMC-ODS will be joining in Prospective Year 2. Their participation in DMC-ODS will increase total administrative costs anticipated to be approximately $902,000 or an increase from .26% to .28% program adjustment percentage.*

iii.___ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate. Please document both trend rates and indicate which trend rate was used.

A. Actual State Administration costs trended forward at the State historical administration trend rate. Please indicate the years on which the rates are based: base years_____ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase.

B. Actual State Administration costs trended forward at the State Plan Service Trend rate. Please indicate the State Plan Service trend rate from **Section D.I.J.a**. above _____.

d.__ 1915(b)(3) Trend Adjustment: The State must document the amount of 1915(b)(3) services in the R1/R2/BY **Section D.I.H.a** above. The R1/R2/BY already includes the actual trend for the 1915(b)(3) services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the R2/BY and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.

1.___ [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1 to trend BY or R2 to P1] The State is using the actual State historical trend to project past data to the current time period *(i.e., trending from 1999 to present).* The actual documented trend is: _____. Please provide documentation.

2.__ [Required, when the State's BY or R2 is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future *(i.e., trending from present into the future)*, the State must use the lower of State historical 1915(b)(3) trend or the State's trend for State Plan Services. Please document both trend rates and indicate which trend rate was used.

i. State historical 1915(b)(3) trend rates

1. Please indicate the years on which the rates are based: base years_____
2. Please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.):

ii. State Plan Service Trend

1. Please indicate the State Plan Service trend rate from **Section D.I.J.a**. above

e.___ Incentives (not in capitated payment) Trend Adjustment: Trend is limited to the rate for State Plan services.

1. List the State Plan trend rate by MEG from **Section D.I.J.a** _____

2. List the Incentive trend rate by MEG if different from **Section D.I.J.a**. _____

3. Explain any differences:

f.___ **Other Adjustments** including but not limited to federal government changes. (Please describe):

- If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
- Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
  - ♦ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
  - ♦ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.

g.___ **Pharmacy Rebate Factor Adjustment (Conversion Waivers Only)*:** Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.

Basis and Method:

1.___ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population ***which includes accounting for Part D dual eligibles***. Please account for this adjustment in **Appendix D5**.

2.___ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS ***or Part D for the dual eligibles***.

3.___ Other (please describe):

4.___ No adjustment was made.

5.___ This adjustment was made (Please describe). This adjustment must be mathematically accounted for in **Appendix D5**.

K. Appendix D5 – Waiver Cost Projection

The State should complete these appendices and include explanations of all adjustments in **Section D.I.I and D.I.J** above.

L. Appendix D6 – RO Targets

The State should complete these appendices and include explanations of all trends in enrollment in **Section D.I.E.** above.

M. Appendix D7 - Summary

a. Please explain any variance in the overall percentage change in spending from BY/R1 to P2.
    1. Please explain caseload changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or the same as the answer given by the State in **Section D.I.E.c & d**:

        DHCS Response

        MCMC and Dental MC: *In P2, the State is projecting an increase in member months for the SPD and SPD Dual eligibility groups due to the mandatory enrollment, with certain exceptions, of dually eligible beneficiaries into the Medi-Cal managed care delivery system on a statewide basis. In the base year and in P1, dually eligible beneficiaries are mandatorily enrolled, with certain exceptions, into the Medi-Cal managed care delivery system in 27 of California's counties, i.e., COHS and CCI counties. The increase to P2 projected member months consists of 205,000 additional members months in the SPD eligibility group (roughly equivalent to 17,000 partial-dually eligible members per month) and 3,660,000 additional member months in the SPD Dual eligibility group (equivalent to 305,000 full-dually eligible members per month).*

        Also in P2, to align with the transition of CCI to a statewide aligned enrollment structure, the State is ending the CCI Dual (non-CMC) and CMC eligibility groups. Members in these eligibility groups are projected to shift to the SPD Dual eligibility group.

        No additional caseload changes are projected for purposes of the cost-effectiveness calculation, as described in Section D, Part I.E. Appendix D1 – Member Months.

        SMHS and DMC-ODS: *The rate of change identified in Column I is due to inflation adjustments and program policy change. The rate of change from R2 to P1 is 4.5 percent. This is due to an inflation adjustment of 6.3*

percent and policy change adjustment of related to the removal of non-pregnancy claims for beneficiaries with unsatisfactory immigration status. The inflation adjustment of 6.3 percent is equal to the percentage change in the Home Health Agency Market Basket Index from the quarter ending June 30, 2019, which is the last quarter in Retrospective Year 2 (Fiscal Year 2018-19), to the quarter ending March 31, 2022, which is the first quarter of Prospective Year 1 (Calendar Year 2022). The program policy change adjustment is equal to the amount of non-pregnancy claims for beneficiaries with unsatisfactory immigration status ($58,985,535.98) divided by the expenditures for mental health and substance use disorder services reported in the September 2018, December 2018, March 2019, and June 2019 quarter CMS 64 reports ($4,130,795,712.28).

The rate of change from P1 to P2 is 3.2 percent. This is due to an inflation adjustment of 2.6 percent and program policy change adjustment of .26 percent. The inflation adjustment of 2.6 percent is equal to the percentage change in the Home Health Agency Market Basket Index from the quarter ending March 31, 2022 (1st quarter of Calendar Year 2022) to the quarter ending March 22, 2023 (1st quarter of Calendar Year 2023). The program policy change adjustment of .26 percent accounts for 10 additional counties starting to provide substance use disorder services through a PIHP delivery system. California estimated the cost of those additional 10 counties would be $11 million based upon costs incurred by counties with similar populations in Fiscal Year 2019-20. California divided $11 million by the R2 expenditures trended forward to Fiscal Year 2019-20 using the percentage change in the Home Health Agency Market Basket Index.

The rate of change from P3 to P4, and P4 to P5 is entirely due to an inflation adjustment. The inflation adjustment for each year is equal to the percentage change in the Home Health Agency Market Basket Index from the 1st quarter of the base year to the 1st quarter of the prospective year.

2. Please explain unit cost changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or the same as the answer given by the State in the State's explanation of cost increase given in **Section D.I.I and D.I.J**:

DHCS Response

MCMC and Dental MC: *The State refers to the descriptions of the State Plan Services trend in Section D.I.J.a, the State Plan Services programmatic adjustments in Section D.I.J.b, and the Administrative Cost adjustment in Section D.I.J.c.*

SMHS and DMC-ODS: *As explained above, the overall annualized rate of change in Appendix D7, Column I includes an inflation adjustment. The inflation adjustment captures anticipated changes in unit costs.*

3. Please explain utilization changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or the same as the answer given by the State in the State's explanation of utilization given in **Section D.I.I and D.I.J**:

   DHCS Response

   MCMC and Dental MC: *The State refers to the descriptions of the State Plan Services trend in Section D.I.J.a and the State Plan Services programmatic adjustments in Section D.I.J.b.*

   SMHS and DMC-ODS: *As explained above, the overall annualized rate of change in Appendix D7, Column I includes three program policy change adjustments. These three program policy change adjustments capture anticipated changes in utilization.*

Please note any other principal factors contributing to the overall annualized rate of change in **Appendix D7 Column I.**

Part II: Appendices D.1-7

Please see attached Excel spreadsheets.

Section 1915(b) Waiver
Proposal for California Advancing and Innovating Medi-Cal (CalAIM)

Attachment I: Dental MC Boilerplate Contract

The Dental MC boilerplate contract is included for reference in the following attachment.

EXHIBIT A, ATTACHMENT 1
IMPLEMENTATION PLAN

This Implementation Plan 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 this contract.

All of the items required by this Attachment must be submitted for approval to DHCS thirty (30) days after contract effective date. 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, no later than thirty (30) calendar days of any material change. The approval process for updates shall be in accordance with Exhibit E, Attachment 2, Duties of the State, Provision E, Approval Process for Submitted Materials during Operations. 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.

Contractor shall submit:

A. Organization and Administration of Plan

Submit the following consistent with the requirements of Exhibit A, Attachment 2.

1. Submit documentation of employees (current and former State employees) who may present a conflict of interest.

2. Submit a complete organizational chart.

3. Submit the following Knox-Keene license exhibits and forms found in 28 CCR 1300.51 et seq reflecting current operation status:

    a. Type of Organization: Submit the following applicable exhibits and forms as appropriate for its type of organization and administration of the dental plan.

        1) Corporation: Exhibits F-1-a-i through F-1-a-iii and Corporation Information Form, Form HP 1300.51-A.
        2) Partnership: Exhibits F-1-b-i and F-1-b-ii and Partnership Information Form, Form HP 1300.51-B.
        3) Sole Proprietorship: Exhibit F-1-c and Sole Proprietorship Information Form, Form HP 1300.51-C.

4) 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.
5) Public Agency: Exhibits F-1-e-I through F-1-e-iii.

28 CR 1300.51(d)F1a – e

b. Exhibit F-1-f: Individual Information Sheet (Form HP 1300.51.1) for each person named in response to item 1) above.

28 CR 1300.51(d)F1f

c. Exhibits F-2-a and F-2-b: contracts with Affiliated person, Principal Creditors and Providers of Administrative Services.

28 CR 1300.51(d)F2

d. Exhibit F-3 Other Controlling Persons.

28 CR 1300.51(d)F

e. 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.

29 Submit Exhibits N-1 and N-2: Contracts for Administrative Services.

28 CCR 1300.51(d)N1&2

B. Financial Information

Submit the following consistent with the requirements of Exhibit A, Attachment 3.

1. Submit most recent audited annual financial reports, prepared by a certified public accountant.

2. Submit quarterly financial statements with the most recent quarter prior to execution of the contract.

3. Submit the following Knox-Keene license exhibits reflecting projected financial viability:

   a. Exhibit HH-1
   b. Exhibit HH-2
   (28 CCR 1300.76)

c. In addition to Exhibit HH-2, include projected Medi-Cal enrollment for each month and cumulative Member months for quarterly financial projections.

4. Submit Knox-Keene license Exhibit HH-6. Include the following:

   a. Exhibit HH-6-a
   b. Exhibit HH-6-b
   c. Exhibit HH-6-c
   d. Exhibit HH-6-d
   e. Exhibit HH-6-e

   28 CCR 1300.51(d)(HH)

5. 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.

6. Fiscal Arrangements: Submit the following Knox-Keene license exhibits reflecting current operation status:

   a. Exhibit II-1
   b. Exhibit II-2
   c. Exhibit II-3

   28 CR 1300.51(d)(II)

7. 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 and 22 CCR 53250.)

8. 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.

9. Submit policies and procedures for a system to evaluate and monitor the financial viability of all subcontracting entities.

C. Management Information System (MIS)

Submit the following consistent with the requirements of Exhibit A, Attachment 4.

1. Submit a completed Managed Care Organization (MCO) Baseline Assessment Form.

2. When procuring a new MIS or modifying a current system, Contractor shall provide a detailed implementation plan that includes:

    a. Outline of the tasks required;
    b. The major milestones;
    c. The responsible party for all related tasks;
    d. A full description of the acquisition of software and hardware, including the schedule for implementation;
    e. Full documentation of support for software and hardware by the manufacturer or other contracted party;
    f. 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;
    g. Documentation of system changes related to the Health Insurance Portability and Accountability Act of 1996 requirements.

3. Submit a detailed description of how Contractor will monitor the flow of encounter data from provider level to the organization.

4. An encounter data test produced from test data processed by the MIS must be submitted. Monthly encounter submissions may not take place until this test has been successfully completed.

5. Submit policies and procedures for the complete, accurate, and timely submission of encounter-level data.

6. Submit a work plan for compliance with the Health Insurance Portability and Accountability Act of 1996.

7. Submit the data security, backup, or other data disaster processes used in the event of a MIS failure.

8. 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:

    a. Financial
    b. Member/Eligibility
    c. Provider
    d. Encounter/Claims
    e. Quality Management/Utilization

9. Submit a sample and description of the following reports generated by the MIS:

    a. Member roster
    b. Provider Listing
    c. Capitation payments
    d. Cost and Utilization
    e. System edits/audits
    f. Claims payment status/processing
    g. Quality Assurance
    h. Utilization
    i. Monitoring of Complaints

D. Quality Improvement System (QIS)

Submit the following consistent with the requirements of Exhibit A, Attachment 5.

1. Submit a written description of the QIS, including:

    a. A flow chart and/or organization chart identifying all components of the QIS and who is involved and responsible for each activity.
    b. A description of the responsibility of the governing body in the QIS.
    c. A description of the QI Committee, including Membership, activities, roles and responsibilities.
    d. A description of how providers will be kept informed of the written QIS, its activities and outcomes.

2. Submit policies and procedures related to the delegation of the QIS activities.

3. Submit boilerplate subcontract language showing accountability of delegated QIS functions and responsibilities.

4. Policies and procedures to address how the Contractor will meet the requirements of:

    a. Quality Improvement Projects
    b. Consumer Satisfaction Survey
    c. Performance Measures

5. Policies and procedures for performance of Primary Care Dentist and specialist site reviews.

6. A list of sites to be reviewed prior to initiating plan operation, existing or in expanded areas.

7. The aggregate results of pre-operational, existing or in expanded areas, site review to DHCS at least six (6) weeks prior to plan operation. The aggregate results shall include all data elements defined by DHCS.

8. Policies and procedures for provider profiling and audits.

9. Policies and procedures for credentialing and revalidation, including licensure and certification of providers and facilities.

10. Policies and procedures for disciplinary actions including, reducing, suspending, or terminating a provider's privileges.

E. Utilization Management (UM)

Submit the following consistent with the requirements of Exhibit A, Attachment 7.

1. Submit written description of UM program that describes appropriate processes to be used to review and approve the provision of dental services. Include:

   a. Procedures for pre-authorization.
   b. A list of services requiring prior authorization and the utilization review criteria.
   c. Procedures for the utilization review appeals process for providers and Members.
   d. Procedures that specify timeframes for dental authorization.
   e. Procedures to detect both under- and over-utilization of dental care services.

2. 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.

F. Provider Network

Submit the following consistent with the requirements of Exhibit A, Attachment 8.

1. Submit a complete provider network that is adequate to provide required covered services for Members in the service area.

2. Submit policies and procedures describing how Contractor will monitor provider to patient ratios to ensure they are within specified standards.

3. Submit policies and procedures regarding dentist supervision of non-dentist practitioners.

4. Submit policies and procedures for providing emergency services.

5. Submit a **complete list** of specialists by type within the Contractor's network.

6. Submit policies and procedures for how Contractor will meet federal requirements for access and reimbursement for in- network and/or out-of- network **Indian Health Care Providers (IHCP) and** Federally Qualified Health Centers (FQHC) services

consistent with Exhibit A, Attachment 8, Provider Network, Provision L, Subcontracts with FQHCs, Rural Health Clinics (RHC) and ~~Indian Health Service Facilities~~ **IHCPs**.

7. 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 8, Provider Network, Provision E, Time and Distance Standard of the Contract.

8. Submit a report containing the names of all subcontracting provider groups (see Exhibit A, Attachment 8, Provider Network, Provision H, Plan Provider Network).

9. 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.

10. 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.

G. Provider Relations

Submit the following consistent with the requirements of Exhibit A, Attachment 9.

1. Submit policies and procedures for provider grievances.

2. Submit protocols for payment and communication with non-contracting providers.

3. Submit copy of Provider Manual.

H. Provider Compensation Arrangements

Submit the following consistent with the requirements of Exhibit A, Attachment 10.

1. Submit policies and procedures for processing and payment of claims.

2. Submit excerpt from the Provider Manual that describes the prohibition of a claim or demand for services provided under the Medi-Cal Dental Managed Care contract, to any Member.

3. Submit Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), and Indian Health ~~Service Facilities~~ **Care Providers (IHCP)** Subcontracts.

4. Submit schedule of capitation rates and/or fee-for-service rates for each of the following provider types:

    a. Primary Care Dentists
    b. Specialists
    c. FQHC

d. RHC
e. **IHCP** ~~Indian Health Service Facility~~

I. Access and Availability

Submit the following consistent with the requirements of Exhibit A, Attachment 11.

1. Submit policies and procedures that include standards for:

   a. Appointment scheduling
   b. Routine specialty referral
   c. Waiting times
   d. After-hours calls
   e. Specialty services

2. 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 11, Access and Availability, Provision C, Access to Services Which Contractor or Subcontractor has a Moral Objection.

3. Submit policies and procedures for standing referrals.

4. Submit policies and procedures regarding 24-hours-a-day access without prior authorization for emergency dental care services.

5. Submit policies and procedures regarding access for disabled Members pursuant to the Americans with Disabilities Act of 1990.

6. Submit policies and procedures regarding Contractor and subcontractor compliance with the Civil Rights Act of 1964.

7. Submit policies and procedures for the provision of 24-hour-a-day interpreter services at all provider network sites.

8. Submit policies and procedures for disaster recovery.

J. Scope of Services

Submit the following consistent with the requirements of Exhibit A, Attachment 12.

1. Submit policies and procedures, including standards, for the provision of the following services for Members under 21 years of age:

   a. EPSDT supplemental services

2. Provide a detailed description of the dental health education system including policies and procedures which address:

    a. Oversight of the Dental Health Education Program;
    b. Delivery of Dental Health Education Programs, Services and Resources;
    c. Evaluation and Monitoring of the Dental Health Education System:
    d. Content of the Dental Health Education Program.

K. Case Management and Coordination of Care

Submit the following consistent with the requirements of Exhibit A, Attachment 13.

1. Submit procedures for monitoring the coordination of care provided to Members.

    For the remaining items, if these items are included in the Provider Manual, submitted under item G.3, 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.

2. Submit policies and procedures for coordinating care of Members who are receiving services from a Primary Care Dentist.

3. Submit policies and procedures for the referral of Members under the age of 21 years that require case management services.

4. Submit a detailed description of Contractor's program for Children with Special Health Care Needs (CSHCN).

5. Submit policies and procedures for identifying and referring children with California Children Services (CCS)-eligible conditions to the local CCS program.

6. Submit policies and procedures for the provision of covered dental services.

L. Member Services

Submit the following consistent with the requirements of Exhibit A, Attachment 14.

1. Submit policies and procedures that address Member's rights and responsibilities. Include method for communicating them to both Members and providers.

2. Submit policies and procedures for the training of Member Services staff.

3. Submit policies and procedures regarding the development content and distribution of information to Members. Address appropriate reading level and translation of materials and include evidence that the materials are at that level.

4. Submit final draft of Member Identification Card and Member Services Guide (Evidence of Coverage and Disclosure Form).

5. Submit policies and procedures for Member selection of a Primary Care Dentist.

6. Submit policies and procedures for Member assignment to a Primary Care Dentist.

7. Submit policies and procedures for notifying Primary Care Dentist that a member has selected or been assigned to the provider within ten (10) calendar days.

8. Submit policies and procedures for notifying Members for denial, deferral, or modification of requests for prior authorization.

M. Member Grievance and Appeal System

Submit the following consistent with the requirements of Exhibit A, Attachment 15.

1. Submit policies and procedures relating to Contractor's Member grievance **and appeal** system.

2. Submit policies and procedures for Contractor's oversight of the Member grievance **and appeal** system for the receipts, processing and distribution including the expedited review of grievances. Please include a flow chart to demonstrate the process.

N. Enrollments and Disenrollments

Submit the following consistent with the requirements of Exhibit A, Attachment 16.

1. Submit policies and procedures for how Contractor will update and maintain accurate information on its contracting Providers.

2. Submit policies and procedures for how Contractor will access and utilize enrollment data from DHCS.

3. Submit policies and procedures relating to Members disenrollment, including Contractor initiated disenrollment.

O. Marketing

Submit the following consistent with the requirements of Exhibit A, Attachment 17.

1. Submit Contractor's marketing plan, including training program and certification of marketing representatives.

2. Submit a copy of boilerplate request form used to obtain DHCS approval of participation in a marketing event.

P. Confidentiality of Medical Information

Submit the following consistent with the requirements of Exhibit E, Additional Provisions, Provision 22, Confidentiality of Medical Information.

1. Submit policies addressing Member's rights to confidentiality of medical/dental information. Include procedures for release of medical/dental information.

ATTACHMENT 1-A
IMPLEMENTATION PLAN DELIVERABLE

Plan Name _____

All implementation deliverables are due 30 days after contract effective date and prior to contract operations. See Exhibit A, Attachment 1, Provision A thru P, for list and details of individual deliverables.

Deliverable	Provision	Date Submitted	Completed
Conflict of Interest documentation for employees	Exhibit A, Attachment 2, Provision C		
Organization chart	Exhibit A, Attachment 2, Provision D		
Knox Keene License exhibits and forms	Exhibit A, Attachment 2, Provision A		
Audited annual financial reports	Exhibit A, Attachment 3, Provision B		
Quarterly financial statement issued prior to contract	Exhibit A, Attachment 3, Provision B		
Knox Keene financial exhibits HH-1, HH-2, projected Medi-Cal enrollment/month	Exhibit A, Attachment 3		
Knox Keene financial exhibits HH-6	Exhibit A, Attachment 3		
Risk sharing/incentive arrangements	Exhibit A, Attachment 3		
Knox Keene exhibits II-1, II-2 and II-3	Exhibit A, Attachment 3		
Subcontractors admin and financial capacity to provide at risk services	Exhibit A, Attachment 3		
Financial Policy for budgeting and operations forecasting.	Exhibit A, Attachment 3		
Policy to monitor financial viability for subcontractors	Exhibit A, Attachment 3		
Managed Care Organization Baseline Assessment form	RFP Main, Attachment 13		

Plan for procuring new or modifying MIS system	Exhibit A, Attachment 4		
Process for encounter data flow	Exhibit A, Attachment 4, Provision B		
Encounter data test	Exhibit A, Attachment 4. Provision A		
Policy for encounter data submission	Exhibit A, Attachment 4, Provision B		
Work plan for HIPAA compliance	Exhibit A, Attachment 4, Provision D		
Process for data security, backup, disaster	Exhibit A, Attachment 4, Provision E		
Process for MIS subsystems	Exhibit A, Attachment 4, Provision A		
Sample and description of MIS reports	Exhibit A, Attachment 4, Provision A		
Description of QIS	Exhibit A, Attachment 5		
Policy related to delegation of QIS activities	Exhibit A, Attachment 5, Provision F		
Boilerplate subcontract language of QIS functions and responsibilities.	Exhibit A, Attachment 5, Provision F		
Policy to address Contractor requirements	Exhibit A, Attachment 5, Provision G		
Policy for Primary Care Dentist (PCD) site reviews	Exhibit A, Attachment 5, Provision K		
List of site reviews prior to operation	Exhibit A, Attachment 5, Provision K		
Aggregate results of site review	Exhibit A, Attachment 5, Provision K		
Policy for provider profiling and audits	Exhibit A, Attachment 5, Provision K		
Policy for provider credentialing and revalidation	Exhibit A, Attachment 5, Provision L		
Policy for disciplinary actions	Exhibit A, Attachment 5, Provision K		
Processes of Utilization Management program	Exhibit A, Attachment 7, Provision A		

Policy for evaluating UM activities for compliance	Exhibit A, Attachment 7, Provision A		
Complete provider network	Exhibit A, Attachment 8, Provision A		
Policy for monitoring provider to patient ratios	Exhibit A, Attachment 8, Provision B		
Policy regarding dentist supervision of non-dentist practitioners	Exhibit A, Attachment 8		
Policy for providing emergency services	Exhibit A, Attachment 8, Provision C		
Complete list of specialists	Exhibit A, Attachment 8, Provision D		
Policy for reimbursement of FQHC,RHC and **IHCP** ~~Indian Health Service Facility~~	Exhibit A, Attachment 8, Provision L		
GeoAccess report of provider networks	Exhibit A, Attachment 8, Provision G		
Report of all subcontracting provider groups	Exhibit A, Attachment 8, Provision H		
Analysis of provider network meeting ethnic, cultural and linguistic needs of Members	Exhibit A, Attachment 8, Provision I		
All boilerplate subcontracts	Exhibit A, Attachment 8, Provision J		
Policy for provider ~~grievance~~ **appeal**s	Exhibit A, Attachment 9, Provision B		
Policy for payment of non-contracting providers	Exhibit A, Attachment 9, Provision C		
Provider Manual	Exhibit A, Attachment 9, Provision D		
Policy for payment of claims	Exhibit A, Attachment 10, Provision D		
Excerpt from Provider Manual describing prohibition of claim or	Exhibit A, Attachment 10, Provision E		

demand for services			
FQHC, RHC and Indian Health Service subcontracts	Exhibit A, Attachment 10, Provision F		
Schedule of per diem rate and/or FFS rate for each provider type	Exhibit A, Attachment 10, Provision A		
Policy for access and availability standards	Exhibit A, Attachment 11, Provision B		
Policy for referrals	Exhibit A, Attachment 11, Provision B		
Policy for emergency access to services	Exhibit A, Attachment 11, Provision D		
Policy for disabled Members	Exhibit A, Attachment 11, Provision F		
Policy for compliance with Civil Rights Act of 1964	Exhibit A, Attachment 11, Provision G		
Policy for 24 hour interpreter services	Exhibit A, Attachment 11, Provision H		
Policy for disaster recovery	Exhibit A, Attachment 11, Provision I		
Policy for EPSDT services	Exhibit A, Attachment 12, Provision C		
Policy for health education system	Exhibit A, Attachment 12, Provision D		
Policy for coordination of care	Exhibit A, Attachment 13		
Policy that address Members' rights and responsibilities	Exhibit A, Attachment 14, Provision A		
Policy for training of Members Services Staff	Exhibit A, Attachment 14, Provision B		
Policy to provide information to Members	Exhibit A, Attachment 14, Provision D		
Member Identification Card and Member Services Guide	Exhibit A, Attachment 14, Provision D		

Policy regarding Member selection of PCD	Exhibit A, Attachment 14, Provision F		
Policy regarding Member assignment to PCD	Exhibit A, Attachment 14, Provision G		
Policy notifying PCD of Member assignment or selection	Exhibit A, Attachment 14, Provision G		
Policy notifying Members of action on prior authorization	Exhibit A, Attachment 14, Provision H		
Policy for Member grievance **and appeal** system	Exhibit A, Attachment 15, Provision A & B		
Policy for oversight of Member grievance **and appeal** system	Exhibit A, Attachment 15, Provision B		
Policy regarding accurate information on providers	Exhibit A, Attachment 16, Provision A		
Policy for utilization of enrollment data from DHCS	Exhibit A, Attachment 16, Provision B		
Policy for Member disenrollment	Exhibit A, Attachment 16, Provision D		
Marketing plan	Exhibit A, Attachment 17, Provision C		
Boilerplate request form to obtain DHCS marketing approval	Exhibit A, Attachment 17, Provision B		
Policy addressing Members right to confidentiality of medical/dental information	Exhibit E, Additional Provisions, Provision 22		

EXHIBIT A, ATTACHMENT 2
ORGANIZATION AND ADMINISTRATION OF THE PLAN

A. 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.

B. Key Personnel (Disclosure Form)

1. Contractor shall file an annual statement with DHCS, no later than thirty (30) calendar days after the beginning of the calendar year, 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:

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

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

   c. Any member of the immediate family of any person designated in a. or b. above.

2. Contractor must submit to DHCS the following disclosures noted below:

a. For any person (individual corporation) with an ownership or control interest in the Contractor or its subcontractors:

i. The name and address. The address for corporate entities must include the primary business address, every business location, and P.O. Box address, as applicable.

ii. The date of birth and Social Security Number (in the case of an individual).

b. Other tax identification number of any corporation with:

i. An ownership or control interest in the Contractor.

ii. Any subcontractor in which the Contractor has 5 percent or more interest.

c. The name of any other disclosing entity in which an owner of the Contractor has an ownership or control interest.

d. The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity.

e. **Disclosures pursuant to 42 CFR § 455.104(b) at the following times:**

i. **When the Contractor submits a proposal in accordance with DHCS' procurement process.**

ii. **When the Contractor executes a contract with DHCS.**

iii. **When DHCS renews or extends its contract with the Contractor.**

iv. **Within 35 days of any change in ownership of the Contractor.**

f. **Any other data, documentation, or information relating to the performance of the entity's obligations pursuant to 42 CFR § 438.604 required by DHCS.**

3. 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~~).

a. Contractor may not knowingly have a relationship of the type described in paragraph c. of this section with the following;

1) An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under federal Executive Order No. 12549 of February 18, 1986 or under guidelines implementing Executive Order No. 12549.

2) An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation at 48 CFR 2.101, of a person described in paragraph a.1) of this section.

b. Contractor may not have a relationship with an individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Social Security Act.

c. The relationships described in paragraph a. of this section, are as follows:

1) A director, officer, or partner of the Contractor.

2) A subcontractor of the Contractor, as governed by 42 CFR 438.230.

3) A person with beneficial ownership of 5 percent or more of the Contractor's equity.

4) **A network provider or person with an employment, consulting or other arrangement with the Contractor for the provision of items and services.**

d. If DHCS finds that Contractor is not in compliance with paragraphs (a) or (b) of this section, DHCS:

1) **May continue an existing agreement with Contractor unless the Secretary of Health and Human Services directs otherwise.**

2) **DHCS may not renew or extend the existing agreement with the Contractor unless the Secretary of Health and Human Services provides to DHCS and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliations.**

C. Conflict Of Interest – Current and Former State Employees

1. This Contract shall be governed by the Conflict of Interest provisions of title 22 CCR § 53600.

~~1.~~ **2.** 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 Sub-provision 2 only, employee in the State civil service is defined to be any person legally holding a permanent or intermittent position in the State civil service.

D. 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:

1. The organization has an accountable governing body.

2. That the Contractor is committed to making this Contract a high priority and supplying any necessary resources to assure full performance of the Contract.

3. 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.

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

5. There are written procedures for the conduct of the business of the Contractor, including the provision of dental services, so as to provide effective controls.

E. Dental Clinical Decisions

Contractor shall ensure that dental clinical decisions, including those by Sub-contractors and rendering Providers, are not unduly influenced by fiscal and administrative management.

F. Dental Director

Contractor shall maintain a full time Dentist as Dental Director pursuant to 22 CCR 53913.5. The Dental Director must maintain a current dental license with the State of California at all times. The license must be in good standing at the time of hire and throughout their employment. The Dental Director shall not be under any sanction or adverse action by Medicaid, or under investigation by the Audits & Investigations Division of DHCS, Department of Justice or any other law enforcement agency. The Dental Director's responsibilities shall include, but not be limited to, the following:

1. Ensuring that dental decisions are:

    a. Rendered by qualified dental personnel.
    b. Are not unduly influenced by fiscal or administrative management considerations.

2. Ensuring that the dental care provided meets the standards for acceptable dental care.

3. Ensuring that dental protocols and rules of conduct for plan dental personnel are followed.

4. Developing and implementing dental policy.

5. Resolving grievances related to dental quality of care.

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

7. Actively participate in the functioning of the Contractor's grievance procedures as specified in Exhibit A, Attachment 15, Member Grievance **and Appeal** System.

G. Dental Director Changes

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

H. 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:

1. Member and Enrollment reporting systems as specified in Exhibit A, Attachment 4, Management Information System, and, Exhibit A, Attachment 14, Member Services, and Exhibit A, Attachment 15, Member Grievance **and Appeal** System.

2. A Member grievance **and appeal** procedure, as specified in Exhibit A, Attachment 15, Member Grievance **and Appeal** System.

3. Data reporting capabilities sufficient to provide necessary and timely reports to DHCS, as required by Exhibit A, Attachment 4, Management Information System.

4. 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 3, Financial Information.

5. Claims processing capabilities as described in Exhibit A, Attachment 10, Provider Compensation Arrangements, Provision E, Claims Processing.

6. A system for providing Members dental health education services and clinical Preventive Services consistent with Exhibit A, Attachment 12, Scope of Services, Provision D, Services for All Members.

7. A provider ~~Grievance~~ **Appeal** procedure.

8. A Quality Improvement System consistent with Exhibit A, Attachment 5.

9. Participate in all meetings with the DHCS.

10. Acknowledge or respond to all correspondence from DHCS in writing.

EXHIBIT A, ATTACHMENT 3
FINANCIAL INFORMATION

A. Financial Viability/Standards Compliance

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

1. Tangible Net Equity (TNE).

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

2. Minimum Loss Ratio **(MLR)**

   a. The Contractor agrees that once the Contractor's plan has a minimum of 1,000 enrolled Members per month for six or more months of a benefit year, the minimum loss ratio for services provided to all Members pursuant to this Contract shall be ~~seventy (70)~~ **eighty-five (85)** percent. For reporting purposes, the Contractor's loss ratio shall be calculated in aggregate for all Members, using the following formula:

      a/b

      Where "a" is: Total covered benefit and service costs of Contractor, including occurred but not reported claim completion **in accordance to 42 CFR 438.8(e)**

      Where "b" is: Total capitation payments received by Contractor, including any withhold payments**, minus taxes, licensing and regulatory fees, in accordance to 42 CFR 438.8(f).**

   b. The Contractor shall report the previous benefit year's loss ratio annually ~~thirty (30) days after the Contractor receives any withhold payments,~~ **and within ~~12 months of the end~~ ninety (90) days of the end of the reporting year. The annual report must include, at minimum, the following information:**

      1) Total incurred claims;
      2) Expenditures on quality improving activities;
      3) Expenditures related to activities compliant with program integrity requirements under 42 CFR 438.608(a)(1) through (5), (7), (8) and (b);
      4) Non-claims costs;
      5) Premium revenue;
      6) Taxes, licensing and regulatory fees;
      7) Methodology for allocation of expenditures;
      8) Any credibility adjustment applied;
      9) The calculated MLR;
      10) Any remittance owed to DHCS, if applicable;
      11) A comparison of the information reported with the audited financial report;

12) A description of the aggregation method used to calculate total incurred claims; and
13) The number of member months.

c. The Contractor understands that DHCS may make the results of the loss ratio report listed in Item 2 above available to the public.

d. The Contractor agrees that if the ~~administrative costs exceed fifteen (15)~~ MLR does not meet the minimum MLR standard of eighty-five (85) percent, DHCS shall have the right to recover from Contractor the amount that is in excess.

e. The Contractor agrees that in the event of a retroactive change to the capitation payments for a MLR reporting year where the MLR report has already been submitted to the state, the Contractor must recalculate and submit a new MLR report meeting the applicable requirements.

f. The Contractor will aggregate data for all Member groups covered under the contract with the state unless the state requires separate reporting and a separate MLR calculation for specific members.

g. The Contractor must attest to the accuracy of the calculation of the MLR in accordance with 42 CFR 438.8.

h. Contractor agrees that each expense must be included under only one type of expense, unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense must be pro-rated between types of expenses. Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be reported on a pro rata basis. Allocation to each category must be based on a generally accepted accounting method that is expected to yield the most accurate results. Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the contract incurring the expense. Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to the other entities.

i. The Contractor may add a credibility adjustment to a calculated MLR if the MLR reporting year experience is partially credible prior to the State recovering excess administrative costs in accordance with 42 CFR 438.8. The credibility adjustment is added before calculating any remittances. If the MLR year is fully credible, then no adjustment is allowed.

j. If the Contractor's MLR experience is non-credible, it is presumed to meet or exceed the MLR calculation standards.

k. The Contractor must submit a comparison of the information reported with the audited financial report along with MLR report.

I. **If the Contractor uses any third party vendor to provide claims adjudication, they must require the vendor, for adjudication activities, to provide all underlying data associated with MLR reporting to the Contractor within 180 days of the end of the MLR reporting year or within 30 days of being requested by the Contractor, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting.**

3. 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.

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

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

   b. 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

   c. 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.

B. Financial Audit Reports

Contractor shall ensure that an annual audit is performed according to Welfare and Institutions Code §~~Section~~ 14459. Financial statements audited by a Certified Public Accountant shall be submitted to DHCS no later than one-hundred and twenty (120) calendar days after the close of Contractor's fiscal year. Combined financial statements 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.

1. The independent accountant shall state in writing reasons for not preparing combined financial statements.

2. 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.

3. In addition to annual certified financial statements, Contractor shall complete the State Department of Managed Health Care (DMHC) required financial reporting forms. The DMHC required financial reporting forms shall be submitted to DHCS no later than one hundred-twenty (120) calendar days after the close of Contractor's Fiscal Year.

4. Contractor shall submit to DHCS, no later than ninety (90) calendar days after the close of the State's fiscal year, a Statement of Revenues and Expenses for Medi-Cal Dental only using the reporting forms in Exhibit A, Attachment 20, Deliverable Templates.

5. Contractor shall submit to DHCS within thirty (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

    f. Schedule F: Unpaid Claims Analysis

    g. Appropriate footnote disclosures in accordance with GAAP

    h. Schedule H: Aging Of All Claims

6. 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.

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

8. 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.

9. Contractor shall submit to DHCS, within forty-five (45) calendar days after the close of State's fiscal quarter, a Statement of Revenues and Expenses for Medi-Cal Dental only using the reporting form in Exhibit A, Attachment 20, Deliverable Templates.

C. Monthly Financial Statements

If Contractor and/or subcontractor is required to file monthly Financial Statements with the DMHC, Contractor and/or subcontractor shall simultaneously file an exact copy of the monthly Financial Statements with DHCS.

D. Compliance with Audit Requirements

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

E. Submittal of Financial Information

Contractor shall prepare financial information requested in accordance with GAAP. Where Financial Statements and projections are requested, these statements and projections 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 in 28 CCR 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.

F. Solvency Standards

1. **Contractor shall comply with the requirements set forth under 42 CFR § 438.116, which includes, but is not limited to, that the Contractor provide assurances satisfactory to the State showing that its provision against the risk of insolvency is adequate such that it ensures that its Medicaid enrollees shall not be held liable for Contractor's debts if the entity becomes insolvent. Federally qualified Health Maintenance Organization (HMO), as defined in Public Health Safety Act Section §1310, are exempt from this requirement.**

2. **Contractor shall meet solvency standards established by the State for private health maintenance organizations, or be licensed or certified by the State as a risk-bearing entity. Contractor shall provide the State with a copy of compliance or exception by January 31st of each calendar year. The above requirement does not apply to a Managed Care Organization (MCO), or Prepaid Inpatient Health Plan (PIHP) that meet any of the following conditions:**
    a. **Does not provide both inpatient hospital services and physician services.**
    b. **Is a public entity.**

c. Is (or is controlled by) one or more Federally Qualified Health Centers and meets the solvency standards established by the State for those centers.

d. Has its solvency guaranteed by the State.

EXHIBIT A, ATTACHMENT 4
MANAGEMENT INFORMATION SYSTEM (MIS)

A. Capability

1. Contractor's MIS shall have the capability to capture, edit, and utilize various data elements for both internal management uses 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:

   a. All Medi-Cal eligibility data.

   b. Information of Members enrolled in Contractor's plan.

   c. Provider claims status and payment data.

   d. Dental services delivery encounter data to include but not be limited to:
      1) Monthly new users;
      ~~1)~~ **2)** Monthly all users;
      ~~2)~~ **3)** Monthly eligible;
      4) Monthly disenrollment for reasons other than loss of eligibility;
      5) Monthly eligible less new users seen in prior months in same calendar year;
      ~~3)~~ **6)** Total paid to each Dentist, including capitation payment, FFS payment, incentive payment and any other payment;
      ~~4)~~ **7)** Calculation of required performance measures.
      8) The provider who delivers services.

   e. Grievance and appeals information.
   ~~e.~~ **f.** Provider network information **including but not limited to:**
      1) Provider office location;
      2) Provider specialties;
      3) Service languages.
      4) All additional provider directory elements specified in Exhibit A, Attachment 14 Member Services and Beneficiary Support, Provision D, Written Member Information.

   ~~f.~~ **g.** Financial information as specified in Exhibit A, Attachment 3, regarding Administrative Duties/Responsibilities.

2. 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 be staffed 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.

~~1.~~ **3.** Contractor shall comply with all DHCS mandated testing of the MIS to determine Contractor compliance with MIS requirements.

4. In accordance with 42 CFR § 433.139(b)-(f), the Contractor shall comply with DHCS's requests to take action to identify, by unique coding, paid claims for Medicaid beneficiaries that contain diagnosis codes that are indicative of trauma, injury, poisoning, and other consequences of external causes, for the purpose of determining the legal liability of third parties so that DHCS may process claims under third party liability payment procedures.

B. 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 Managed Care Plans, Encounter Data Element Dictionary and All Plan Letters (APL) related to encounter data reporting for Medi-Cal Dental Managed Care Plan contractors **in the form and manner prescribed in 42 CFR § 438.818**. **The contractor shall submit encounter data to the state in standardized Accredited Standards Committee (ASC) X12N 837 and National Council for Prescription Drug Programs (NCPDP) formats, and the ASC X12N 835 format as appropriate.**

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**, and certified by the CEO or CFO** prior to submission to DHCS **according to Exhibit E, Section 12, Data Certifications**. Contractor shall submit encounter data to DHCS on a monthly basis in the form and manner specified in DHCS' most recent Managed Care Plans, Data Element Dictionary.

Upon written notice by DHCS that the encounter data is insufficient or inaccurate, Contractor shall ensure that corrected data is resubmitted within fifteen (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 to be captured in the following month's production run.

If encounter data is not submitted within fifteen (15) calendar days of receipt of DHCS' notice and an approved extension was not attained, DHCS will notify the Contractor in writing of their violation of contract terms and reserves the right to suspend all new enrollments.

C. 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 thirty (30) calendar days from the date of the postmark of DHCS' written notice to Contractor. Within thirty (30) calendar days of DHCS' receipt of Contractor's corrective action plan, DHCS shall approve the corrective action plan or request revisions. Within fifteen (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.

D. 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. The Contractor shall also comply with the requirements of the DHCS' Information Security Office Information Technology Project Security Requirements 1 (SR1). (See Data Library for document)

E. Data Security and Backup

Contractor must submit a data security backup plan to include data disaster recovery processes in the event of an MIS failure for DHCS approval. Contractor shall submit any revisions, updates and/or changes in writing to DHCS for approval fifteen (15) calendar days prior to implementing the proposed revision, update and/or change.

EXHIBIT A, ATTACHMENT 5
QUALITY IMPROVEMENT SYSTEM

A. General Requirement

1. 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. In accordance with 42 CFR § 438.330, the Contractor shall establish and implement an ongoing comprehensive quality assessment and performance improvement program. which must include at least the following elements:

a. Quality Improvement Projects in accordance with Provision H of Exhibit A, Attachment 5, including any required by DHCS or CMS that focus on both and non-clinical areas.

b. Collection and submission of performance measurement data required by DHCS or CMS in accordance with Exhibit A, Attachment 6, Performance Measures and Benchmarks.

c. Mechanisms to detect both underutilization and overutilization of services.

d. Mechanisms to assess the quality and appropriateness of care furnished to Members with special health care needs, as defined by the state, and further specified in Exhibit A, Attachment 13.

B. 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 dental director, and the inclusion of contracting dentists and contracting providers in the process of QIS development and performance review. Participation of non-contracting providers is at the Contractor's discretion.

C. Governing Body

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

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

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

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

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

D. 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 dental director or a dentist designee. Contractor must ensure that 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.

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.

E. Provider Participation

Contractor shall ensure that contracting dentists 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.

F. Delegation of Quality Improvement Activities

1. 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:

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

    b. Contractor's oversight, monitoring, and evaluation processes and subcontractor's agreement to such processes.

    c. 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.

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

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

    a. 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.

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

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

G. Quality Improvement System (QIS) Manual

Contractor shall implement and maintain a QIS manual. The QIS manual shall be due to DHCS for approval prior to commencement of the contract and any revisions, updates and/or changes shall be submitted in writing to DHCS within fifteen (15) calendar days of the change.

The QIS manual shall include the following:

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

2. 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.

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

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

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

6. The processes and procedures designed to ensure that all medically necessary dental 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.

7. A description of the mechanisms used to continuously review, evaluate, and improve access to and availability of services**, including detection of both underutilization and overutilization**. The description shall include methods to ensure that Members are able to obtain appointments within established standards. (See Exhibit A, Attachment 11, Access and Availability, Provision B, Access Requirements, Subprovision 2.)

8. Description of the quality of dental services provided, including, but not limited to, preventive services for children and adults, specialty services, and emergency services.

9. Description of the activities designed to assure the provision of case management, coordination and continuity of care services.

10. A description of the process used to track dental and medical referrals from initiation of the referral to the completion.

H. Quality Improvement Projects (QIPs)

1. For this Contract, Contractor is required to conduct or participate in two (2) Quality Improvement Projects (QIPs) per year approved by DHCS. **Each QIP must be designed to achieve significant improvement, sustained over time, in health outcomes and Member satisfaction.**

   a. One (1) QIP must be either an Internal Quality Improvement Project (IQIP) or a Small Group Collaborative (SGC) facilitated by a dental plan or DHCS. The SGC must include a minimum of two (2) DHCS dental 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.

b. One (1) QIP must be a DHCS established and facilitated Statewide Collaborative beginning after start of operations.

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

d. Contractor shall comply with the initial All Plan Letter to be distributed thirty (30) days after contract effective date as well as any subsequent updates**,** and shall use the QIP reporting format designated therein to request approval of proposed QIPs from DHCS and report at least quarterly 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:

1) In-depth qualitative and quantitative analysis of barriers and results.

2) Evidence-based interventions and best practices, when available, and system wide intervention, when appropriate.

3) Interventions that address health disparities.

4) Measurement of performance using objective quality indicators.

5) Implementation of interventions to achieve improvement in the access to and quality of care.

6) Evaluation of the effectiveness of the interventions based on the performance measures in Exhibit A, Attachment 6 Performance Measures and Benchmarks.

7) Planning and initiation of strategies for sustaining ~~and~~ **or** ~~spreading~~ **increasing** improvement beyond the duration of the QIP.

I. Quality Improvement Annual Report

Contractor shall develop an annual quality improvement report for submission to DHCS on an annual basis due no later than thirty (30) calendar days after the beginning of the calendar year.

The annual report shall include:

1. 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 Performance Measures; and, outcomes/findings from Quality Improvement Projects (QIPs), consumer satisfaction surveys and collaborative initiatives.

2. Copies of all final reports of any non-governmental accrediting agencies relevant to the Contractor's Medi-Cal line of business, including accreditation status and any deficiencies noted. Include the corrective action plan developed to address noted deficiencies.

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

J. External Quality Review Requirements

At least annually, or as designated by DHCS, the Contractor shall arrange for an external quality of care review of the Contractor by an entity qualified to conduct such reviews. Contractor shall submit the selected External Quality Review Organization (EQRO) thirty (30) days after contract effective date to be approved by DHCS. Contractor shall be responsible for payment of the EQRO.

1. Performance Measure Audit

   The performance measures consist of a set of DHCS developed measures for evaluation of dental plan performance.

   a. On an annual basis, Contractor shall submit to an on-site audit to assess the Contractor's information and reporting systems, as well as the Contractor's methodologies for calculating performance measure rates.

   b. Contractor shall calculate and report all performance measures at the county level for audit by the EQRO.

   c. Contractor shall provide DHCS with a copy of the audit report no later than December 15 or such date as established by DHCS.

   d. Contractor shall meet or exceed the DHCS established benchmark for each performance measure.

2. Consumer Satisfaction Survey

   At intervals determined by DHCS, the EQRO will conduct one (1) consumer satisfaction survey per year. The survey of Member satisfaction with plan and providers shall be the same dental version of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey as used by the Healthy Families Program. The survey shall include 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.

3. **Network Adequacy Standards**

   In accordance with 42 CFR § 438.68, on an annual basis, the EQRO shall validate the Contractor's compliance with the provider network adequacy standards as set forth in Exhibit A, Attachment 1, Provider Network, Provision F.

K. Site Review

1. General Requirement

   Contractor shall conduct site reviews on all Primary Care Dentist and specialist service sites.

2. 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 dental care and specialist sites in the provider network. For more than thirty (30) sites in the provider network, a five (5) percent sample size or a minimum of thirty (30) sites, whichever is greater in number, shall be reviewed six (6) weeks prior to plan operation. Reviews shall be completed on all remaining sites within six (6) months of plan operation. For thirty (30) or fewer sites, reviews shall be completed on all sites six (6) weeks prior to plan operation.

3. 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 revalidation.

4. Provider Monitoring

   Contractor shall monitor its Providers using Quality Improvement thresholds established by DHCS. The quality indicators to be monitored are as follows, but not limited to:

   a. Service site audit findings based on Exhibit A, Attachment 11, Access and Availability, Provision B, Access Requirements, Subprovision 2.

   b. Dental Record (chart) audit findings based on Exhibit A, Attachment 5, Quality Improvement System, Provision M, Dental Records, Subprovision 4.

   c. Utilization Review of Encounter Data based on Encounter Data Submittal requirements in Exhibit A, Attachment 4, Management Information System,

Provision B, Encounter Data Submittal and performance measures in Exhibit A, Attachment 6.

DHCS reserves the right to modify or add additional quality indicators through an All Plan Letter.

Contractor shall review, on a quarterly basis, a minimum of five (5) active providers from their network for compliance with the quality indicators. Contractor shall submit a Provider Monitoring Report, in a format specified by DHCS in Exhibit A, Attachment 20, Deliverable Templates for each Provider reviewed for the quality indicators and any others required through an APL. The report shall detail the quality indicators that each Provider did not meet and describe the Contractor's plan to remediate the deficiency. This report shall include a narrative summary of all Quality Improvement System actions relating to Providers and shall be submitted quarterly to DHCS. The report is due to DHCS within thirty (30) calendar days following the quarter.

If DHCS acquires any negative information regarding a provider subcontracted with the Contractor, the Contractor may be required to conduct a review or audit of that provider.

5. Continuing Oversight

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

L. Credentialing and Revalidation

Contractor shall develop, and maintain **uniform** written policies and procedures that include initial credentialing, revalidation, recertification, and reappointment of dentists including Primary Care Dentists and specialists in accordance with Dental Managed Care All Plan Letter ~~to be~~ executed at contract effective date **and 42 CFR 438.214(b)**. 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. Contractor shall submit to DHCS the policies and procedures for initial credentialing, revalidation, recertification, and reappointment of dentists including Primary Care Dentists, specialists and non-dentist practitioners thirty (30) days after contract effective date for review and approval. Any revisions, updates and/or changes shall be submitted in writing to DHCS within fifteen (15) calendar days of the change.

1. Standards

All providers ~~of~~ **that deliver** covered services **and have signed contracts or participation agreements with Contractor,** 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 must have 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.

2. Delegated Credentialing

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

3. Credentialing Provider organization Certification

   Contractor and their subcontractors may obtain credentialing provider organization certification (POC) from the National Committee for Quality Assurance (NCQA). Contractor may accept evidence of NCQA POC certification in lieu of a monitoring visit at delegated provider organizations.

4. Disciplinary Actions

   Contractor shall implement and maintain a system for the reporting of serious quality deficiencies that result in suspension or termination of a provider to DHCS and the appropriate authorities. Contractor shall implement and maintain policies and procedures for disciplinary actions including, reducing, suspending, or terminating a provider's privileges. Contractor shall implement and maintain a provider appeal process. All policies and procedures shall be submitted and approved by DHCS thirty (30) days prior to operations.

5. 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 (www.Medi-Cal.ca.gov). 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.

6. Health Plan Accreditation

   a. The Contractor shall inform the State whether it has been accredited by a private independent accrediting entity.

   b. The Contractor must authorize the private independent accrediting entity to provide the State a copy of its most recent accreditation review, including:

      1) Accreditation status, survey type, and level (as applicable);

      2) Accreditation results, including recommended actions or improvements, corrective action plans, and summaries of finding;

      3) Expiration date of the accreditation.

If Contractor has received a rating of “Excellent”, “Commendable”, or “Accredited’ from NCQA, the Contractor shall be “deemed” to meet this DHCS requirements for credentialing and will be exempt from the DHCS 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.

7. Credentialing of Other Non-Dentist Practitioners

   Contractor shall develop and maintain policies and procedures that ensure that the credentials of non-dentists have been verified in accordance with State requirements applicable to the provider category.

8. Changes to Credentialing and Revalidation Policies

   ~~Any~~ **Future** policy changes regarding credentialing and revalidation **may** ~~will~~ be issued through an All Plan Letter. Contractor must make amendments to its policies and procedures in accordance to the policy change(s).

M. Dental Records

1. General Requirement

   Contractor shall ensure that appropriate dental records for Members, pursuant to 28 CCR 1300.80(b)(4) and 42 USC 1396a(w), shall be available to providers at each encounter in accordance with 28 CCR 1300.67.1(c).

2. Dental Records

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

   a. For storage and filing of medical records including: collection, processing, maintenance, storage, retrieval identification, and distribution in accordance with federal and State laws.

   b. To ensure that dental records are protected and confidential in accordance with all federal and State laws.

   c. For the release of information and obtaining consent for treatment.

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

3. On-Site Dental Records

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

4. Member Dental Record

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

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

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

   c. 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.

   d. A complete record of all services rendered.

   e. A complete medical and dental history, including prominent notation in the record of allergies and adverse reactions. The medical history is to be updated at every visit, with a notation to that effect in the record.

   f. All informed consent documentation.

5. All emergency care provided by the contracted provider or non-contracting provider.

6. Consultations, referrals (dental and medical), specialists' reports.

7. Oral health instruction.

8. 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 (5) 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 or dental records, and prescription files.

N. Evaluation of Contractor Compliance/Corrective Action Plan (CAP)

DHCS will evaluate Contractor's overall compliance with contract requirements monthly. 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 the dental managed care All Plan Letter to be executed at contract effective date. If Contractor fails to correct cited deficiencies as specified in the All Plan Letter, then the DHCS reserves the right to halt all new enrollment to the plan until such time as the deficiencies have been corrected and approved by the Department.

EXHIBIT A, ATTACHMENT 6
PERFORMANCE MEASURES AND BENCHMARKS

A. Determination of Performance

DHCS has established performance measures for evaluation of dental health plan performance. These performance measures will be used to monitor plan utilization and services of Members. Contractor's utilization performance will be evaluated based upon eleven (11) separate measures. DHCS will assign the point values indicated in Column C in the tables below to the annual utilization rates achieved on each measure and each age group within each measure. The point values will be totaled and a portion of the withheld ten (10) percent of the monthly Capitation Payment will be paid to the Contractor according to the following schedule:

Total Points	Portion of 10% Withhold Paid to Contractor
0-150	0%
155-270	25%
275-390	50%
395-410	75%
415-570	100%

B. Bonus Payment

DHCS will award Contractor a bonus payment of up to five (5) percent of the monthly Capitation Payment for exceptional performance on the selected utilization measures and age groups indicated in Column D in the tables below, according to the following schedule:

Total Points	Portion of 5% Bonus Paid to Contractor
0-100	0%
120-180	25%
200-280	50%
300-380	75%
400-480	100%

C. Performance Measures

1. The eleven (11) performance measures are as follows:

   a. Annual Dental Visits – Percentage of Members who had at least one (1) dental visit during the measurement year.

      Calculation

Numerator: Number of Members enrolled in the same plan during the measurement year for at least ninety (90) continuous days who received any dental procedure (D0100-D9999) during that period.

Denominator: Number of Members enrolled in the same plan during the measurement year for at least ninety (90) continuous days.

Benchmarks

A	B	C	D
Age Group	Benchmark (BM)	Points if Meet or Exceed BM	Points for Bonus if Exceed BM by > 5 Percentage Points
0-3	30.3	10	20
4-5	66.6	10	20
6-8	64.1	5	
9-11	61.4	5	
12-14	54.9	5	
15-18	48.6	5	
19-20	33.7	5	
2-18	56.5	5	

b. Continuity of Care – percentage of Members continuously enrolled in the same plan for two (2) years with no gap in coverage who received a comprehensive oral evaluation or a prophylaxis in both the year prior to the measurement year and in the measurement year.

Calculation
Numerator: Number of Members in the denominator who also received a comprehensive or periodic oral evaluation (D0120, D0150) or a prophylaxis (D1110, D1120) in the measurement year.

Denominator: Number of Members continuously enrolled in the same plan for two (2) years with no gap in coverage who received a comprehensive oral evaluation (D0120, D0150) or a prophylaxis (D1110, D1120) in the year prior to the measurement year.

Benchmarks

A	B	C	D
Age Group	Benchmark (BM)	Points if Meet or Exceed BM	Points for Bonus if Exceed BM by > 5 Percentage Points
0-3	69.6	10	20
4-5	71.4	10	20
6-8	68.1	5	

9-11	65.9	5	
12-14	62.3	5	
15-18	59.6	5	
19-20	52.8	5	
0-18	65.2	5	

c. Use of Preventive Services – percentage of Members who received any preventive dental service during the past year.

Calculation
Numerator: Number of Members enrolled in the same plan during the measurement year for at least ninety (90) continuous days who received any preventive dental service (D1000-D1999) in the measurement year.

Denominator: Number of Members enrolled in the same plan during the measurement year for at least ninety (90) continuous days.

Benchmarks

A	B	C	D
Age Group	Benchmark (BM)	Points if Meet or Exceed BM	Points for Bonus if Exceed BM by > 5 Percentage Points
0-3	22.3	10	20
4-5	55.4	10	20
6-8	55.2	5	
9-11	52.6	5	
12-14	47.0	5	
15-18	38.9	5	
19-20	24.9	5	
0-18	43.5	5	

d. Use of Sealants – percentage of Members ages six (6) through nine (9) and ten (10) through fourteen (14) enrolled in the same plan during the measurement year for at least ninety (90) continuous days who received a dental sealant on at least one (1) permanent molar tooth.

Calculation
Numerator: 1) Number of Members ages six (6) through nine (9) enrolled in the same plan during the measurement year for at least (90) continuous days who received a dental sealant (D1351) on a permanent first molar (Tooth Number = 3, 14, 19, 30), and 2) Number of Members ages ten (10) through fourteen (14) enrolled in the same plan during the measurement year for at least (90) continuous days who received a dental sealant (D1351) on a permanent second molar (Tooth Number = 2, 15, 18, 31), respectively.

Denominator: Number of Members ages six (6) through nine (9) and ten (10) through fourteen (14), respectively, enrolled in the same plan during the measurement year for at least (90) continuous days.

Benchmarks

A	B	C	D
Age Group	Benchmark (BM)	Points if Meet or Exceed BM	Points for Bonus if Exceed BM by > 5 Percentage Points
6-9	19.2	5	10
10-14	14.2	5	10

e. Sealant to Restoration Ratio (Surfaces) – The ratio of occlusal surfaces of permanent first and second molars receiving dental sealant to those receiving restoration among Members ages six (6) through nine (9) and ten (10) through fourteen (14) enrolled in the same plan during the measurement year for at least (90) continuous days.

Calculation
Numerator: Number of occlusal surfaces of permanent first molars (Tooth Number = 3, 14, 19, 30) in six (6) through nine (9) and ten (10) through fourteen (14) year-olds and of permanent second molars (Tooth Number = 2, 15, 18, 31) in ten (10) through fourteen (14) year-olds receiving dental sealant (D1351) among Members in those age groups enrolled in the same plan during the measurement year for at least (90) continuous days.

Denominator: Number of occlusal surfaces of permanent first molars (Tooth Number = 3, 14, 19, 30) in six (6) through nine (9) and ten (10) through fourteen (14) year-olds and of permanent second molars (Tooth Number = 2, 15, 18, 31) in ten (10) through fourteen (14) year-olds receiving a restoration (D2000-D2999)

among Members in those age groups enrolled in the same plan during the measurement year for at least (90) continuous days.

Benchmarks

A	B	C	D
Age Group	Benchmark (BM)	Points if Meet or Exceed BM	Points for Bonus if Exceed BM by > 5 Percentage Points
6-9	3.57	5	10
10-14	1.74	5	10

f. Treatment/Prevention of Caries – percentage of Members who received either treatment for caries or a caries-preventive procedure during the past year.

Calculation
Numerator: Number of Members enrolled in the same plan during the measurement year for at least (90) continuous days who received a treatment for caries (D2000-D2999) or a caries-preventive procedure (D1203-D1206, D1310, D1330, D1351) during the past year.

Denominator: Number of Members enrolled in the same plan during the measurement year for at least (90) continuous days.

Benchmarks

A	B	C	D
Age Group	Benchmark (BM)	Points if Meet or Exceed BM	Points for Bonus if Exceed BM by > 5 Percentage Points
0-3	10.0	10	20
4-5	33.1	10	20
6-8	40.7	5	
9-11	36.1	5	
12-14	34.0	5	
15-18	27.8	5	
19-20	17.5	5	
0-18	28.2	5	

g. Exams/Oral Health Evaluations - The percentage of Members who received a comprehensive or periodic oral health evaluation or, for Members under three (3) years of age, who received an oral evaluation and counseling with the primary care giver, during the past year.

Calculation

Numerator: Number of Members enrolled in the same plan during the measurement year for at least (90) continuous days who received a comprehensive or periodic exam (D0120 or D0150) or, for Members under three (3) years of age, who received an oral evaluation and counseling with the primary caregiver (D0145), during the past year.

Denominator: Number of Members enrolled in the same plan during the measurement year for at least (90) continuous days.

Benchmarks

A	B	C	D
Age Group	Benchmark (BM)	Points if Meet or Exceed BM	Points for Bonus if Exceed BM by > 5 Percentage Points
0-3	23.9	10	20
4-5	56.7	10	20
6-8	55.5	5	
9-11	53.0	5	
12-14	47.5	5	
15-18	40.6	5	
19-20	27.8	5	
0-18	44.5	5	

h. Overall Utilization of Dental Services – percentage of Members continuously enrolled for one (1), two (2), and three (3) years who received any dental service during those periods

Calculation
Numerator: Number of Members continuously enrolled in the same plan for one (1), two (2), and three (3) years with no break in eligibility who received any dental service (D0100-D9999) during those periods.

Denominator: Number of Members continuously enrolled in the same plan for one (1), two (2), and three (3) years, respectively.

Note: For plans enrolling new Members beginning in 2012, this measure will not come into play for those Members until the end of the first full year, although it can still be applied for existing Members who have remained in a plan for the requisite number of years.

Benchmarks

A	B			C	D
	Benchmark (BM)				
Age Group	Yr 1	Yr 2	Yr 3	Points if Meet or Exceed BM	Points for Bonus if Exceed BM by > 5

					Percentage Points
0-3	31.4	47.6	62.7	10	20
4-5	66.9	79.4	83.5	10	20
6-8	64.7	79.2	85.4	5	
9-11	61.4	77.4	85.0	5	
12-14	55.3	71.8	80.5	5	
15-18	48.1	64.0	72.5	5	
19-20	34.3	50.1	59.7	5	
0-18	53.1	70.9	81.2	5	

i. Usual Source of Care -- Percentage of Members who received any dental service each year for two (2) consecutive years

Calculation
Numerator: Number of Members continuously enrolled in the same plan for two (2) consecutive years who received at least one (1) dental service in each of those years.

Denominator: Number of Members continuously enrolled in the same plan for two (2) consecutive years

Benchmarks

A	B	C	D
	Benchmark (BM)	Points if Meet or Exceed BM	Points for Bonus if Exceed BM by > 5 Percentage Points
0-3	11.8%	10	20
4-5	38.0%	10	20
6-8	45.9%	5	
9-11	42.0%	5	
12-14	36.5%	5	
15-18	31.2%	5	
19-20	22.3%	5	
0-18	34.1%	5	

j. Use of Dental Treatment Services – Percentage of Members who received any dental treatment service during the past year.

Calculation

Numerator: Number of Members enrolled in the same plan during the measurement year for at least (90) continuous days who received any dental treatment service (D2000-D9999) in the measurement year.

Denominator: Number of Members enrolled in the same plan during the measurement year for at least (90) continuous days.

Benchmarks

A	B	C	D
	Benchmark (BM)	Points if Meet or Exceed BM	Points for Bonus if Exceed BM by > 5 Percentage Points
0-3	9.0%	10	20
4-5	33.1%	10	20
6-8	38.4%	5	
9-11	34.3%	5	
12-14	29.3%	5	
15-18	28.1%	5	
19-20	21.3%	5	
0-18	27.3%	5	

k. Preventive Services to Fillings – Percentage of Members who received one (1) or more fillings in the measurement year who also received preventive services (topical fluoride application, sealant, preventive resin restoration, education) in the measurement year.

Calculation
Numerator: Number of Members enrolled in the same plan during the measurement year for at least (90) continuous days who received one (1) or more fillings (D200-D2999) in the measurement year and who also received one (1) or more topical fluoride applications (D1203, D1204 or D1206), dental sealants (D1351), preventive resin restorations (D1352) or education to prevent caries (D1310 or D1330) in the measurement year.

Denominator: Number of Members enrolled in the same plan during the measurement year for at least (90) continuous days, who received one (1) or more fillings (D2000-D2999) in the measurement year.

Benchmarks

A	B	C	D
	Benchmark (BM)	Points if Meet or Exceed BM	Points for Bonus if Exceed BM by > 5 Percentage Points
0-3	71.7%	10	20
4-5	66.6%	10	20
6-8	72.0%	5	
9-11	71.2%	5	
12-14	62.0%	5	
15-18	41.2%	5	
19-20	25.8%	5	
0-18	62.3%	5	

2. Contractors will submit all the necessary encounter data to capture the eleven (11) measures. The data must be submitted within six (6) months of the date of service.

3. DHCS will monitor the performance measures on a monthly basis. Contractor will be notified if DHCS identifies a problem with the Contractor's performance or feels that the Contractor is in jeopardy of not achieving the benchmark at their annual review.

B. Performance Measures and Benchmarks

Each performance measure will have approved DHCS benchmarks. These performance measures and benchmarks will be reevaluated each year. DHCS will notify Contractor at the beginning of each measurement year of the new required performance measures

and benchmarks. Contractor shall meet or exceed the benchmark for each measure and/or any other performance measure established by DHCS.

C. Online Posting of Utilization Data

Upon completion of DHCS' annual evaluation of performance measures, DHCS will publish all results of the Contractor's performance on the Denti-Cal website (www.denti-cal.ca.gov).

EXHIBIT A, ATTACHMENT 7
UTILIZATION MANAGEMENT

A. 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 dental covered services as identified in the Medi-Cal Dental Manual of Criteria. Contractor is responsible to ensure that the UM program includes:

1. Qualified staff responsible for the UM program.

2. The separation of dental care decisions from fiscal and administrative management to assure dental care decisions will not be unduly influenced by fiscal and administrative management.

3. Allowances for a second opinion from a qualified dental professional at no cost to the Member.

4. 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.

5. Communications to dental providers of the procedures and services that require prior authorization and ensure that all contracting dental providers are aware of the procedures and timeframes necessary to obtain prior authorization for these services.

6. 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 dental providers and non-contracting specialty providers are informed of the prior authorization and referral process at the time of referral.

7. 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 **grievances and** appeals, denials, deferrals, and modifications to the appropriate QIS staff.

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

   These activities shall be done in accordance with Health and Safety Code Section 1367.1 and 28 CCR 1300.70(a)(3) and (c).

9. **In accordance with 42 CFR 438.210(e), and consistent with 42 CFR 438.3(i) and 42 CFR 422.208, compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any Member.**

B. ~~Pre-~~Authorization~~s~~ and Review Procedures

Contractor shall ensure that its ~~pre-authorization~~ procedures **for processing prior-authorization, continuing, and retrospective requests for services** are in accordance with the Medi-Cal Dental policy and procedures as described in the Medi-Cal Dental Manual of Criteria~~,~~ **and Health and Safety Code Section 1367.01(h).** ~~and meet the following minimum requirements:~~**The following minimum requirements must be met:**

1. Qualified dental professionals supervise review decisions, and a qualified dentist will review all denials.

2. There is a set of written criteria or guidelines for Utilization Review that is based on the dental standard of care, is consistently applied, regularly reviewed, and updated.

3. Reasons for decisions are clearly documented.

4. Notification to Members regarding denied, deferred or modified referrals is made as specified in Exhibit A, Attachment 14, Member Services. There shall be a well-publicized **grievances and** appeals procedure**s** for both providers and Members.

5. Decisions and appeals **concerning adverse benefit determinations and grievances,** are made in a timely manner and are not unduly delayed for dental conditions requiring time sensitive services**, in accordance with Attachment 15**.

6. Prior Authorization requirements shall not be applied to emergency services.

7. Records, including any Notice of Action, shall meet the retention requirements described in Exhibit E, Additional Provisions, Provision 20, Audit.

8. The requesting provider is notified 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. Notification must always be sent to the provider in writing. Verbal notice may also be given to the provider, but must be followed up by the written notification. **Contractor and its subcontractors must consult with the requesting provider for medical services when appropriate.**

Upon request, Contractor shall provide a list of all services requiring prior authorizations.

C. Timeframes for Dental Authorization

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

Emergency care must be readily available and accessible within the service area twenty-four (24) hours a day, seven (7) days a week.

2. Routine authorizations: Within five (5) business days from the receipt of the information that is reasonably necessary to render a decision (these are requests for specialty service, cost control purposes, out-of-network services 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. **If Contractor extends the timeframe for providing a Notice of Adverse Benefit Determination for standard authorizations decisions beyond 14 days, Contractor must give the member written notice of the reason for the extension and inform the member of their right to file a grievance if he or she disagrees with the decision. If Contractor extends the 14 calendar day notice of adverse benefit determination timeframe for standard authorization decisions that deny or limit services, it must issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.**

3. Expedited authorizations: **In accordance with 42 CFR 438.210(d), ~~F~~ f**or 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 **72 hours** ~~**three (3) business days**~~ after receipt of the request for services. The Contractor may extend the **72 hour** ~~**three (3) business 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.

4. **Contractor shall give member notice when service authorization decisions are not reached within the applicable timeframes for either standard or expedited service authorizations on the date that the applicable timeframes expire.**

D. Review of Utilization Data

Contractor shall include within the UM program mechanisms to detect both under- and over-utilization of dental services. Contractor shall suspend all new enrollments for a provider who does not meet the thresholds of utilization. Reinstatement of enrollment may proceed once thresholds are met. Contractor's internal reporting mechanisms used

to detect Member utilization patterns shall be reported to DHCS no later than thirty (30) calendar days after the beginning of each calendar year.

Contractor shall submit self-reported monthly utilization data by Primary Care Dentist service site as determined by DHCS in an All Plan Letter. The report shall be submitted thirty (30) calendar days after the end of each reporting month.

E. Delegating UM Activities

Contractor may delegate UM activities. If Contractor delegates these activities, Contractor shall comply with Exhibit A, Attachment 5, Quality Improvement System, Provision F, Delegation of Quality Improvement Activities.

EXHIBIT A, ATTACHMENT 8
PROVIDER NETWORK

A. Network Capacity

Contractor shall submit a complete provider network including provider compensation agreements to DHCS for approval thirty (30) days after contract effective date that is adequate to provide required covered services for Members in the service area. Contractor will increase the capacity of the network as necessary to accommodate enrollment growth.

B. Provider to Member Ratios

1. Contractor shall be in accordance with 28 CCR 1300.67.2 Accessibility of Services, and submit the methodology used to monitor Member ratio to DHCS for approval prior to the commencement of the Operations Period.

2. Contractor shall assess each Primary Care Dentist's enrollment capacity. Enrollment capacity shall be assessed by Contractor using factors including, but not limited to:

    a. Appointment availability.

    b. Use of professional and ancillary dental personnel including, but not limited to, Registered Dental Assistants and Registered Dental Hygienists.

    c. Specific "office efficiencies" including, but not limited to, the number of available operators and extended office hours;

    d. Existing number of Members;

    e. Existing number of active (non-Member) patients; and

    f. Full time equivalent dentists, hygienists, and dental assistants devoted to clinical activities.

C. Emergency Services

Contractor shall ensure that a Member with an emergency dental condition will be seen immediately and emergency services shall be available and accessible within the service area on a 24-hours-a-day, 7-days-a-week basis.

D. Specialists

Contractor shall provide accessibility to required specialists who are certified or eligible for certification by the appropriate specialty board, through contracting or referral. Contractor shall maintain adequate numbers and types of specialists within their network to accommodate the need for specialty care. 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.

Contractor shall actively conduct outreach activities to subcontract with Pediatric Dentists in the service area, including specific attempts to recruit them as Primary Care Dentists and include them as part of the Contractor's provider network. The Contractor must submit a quarterly detailed written report to DHCS highlighting the activities associated with active recruitment. This report shall be submitted to DHCS within fifteen (15) days following the end of the quarter.

E. Time and Distance Standard

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

F. Adequate Facilities and Personnel

Contractor shall demonstrate the continuous availability and accessibility of adequate numbers of service locations, and professional and ancillary dental personnel to provide covered services. **Adequate facilities and personnel shall be sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of Members in the service area, and as prescribed in federal and state law.**

G. Changes to Provider Network Report

Contractor shall submit to DHCS monthly in a format specified by DHCS in Exhibit A, Attachment 19, Deliverable Template, a report identifying deletions and additions in the provider network.

1. The report shall identify provider deletions and additions and the resulting impact to:
    a. Geographic access for the Members.
    b. Cultural and linguistic services including provider and provider staff language capability.
    c. The number of Members assigned to each Primary Care Dentist.
    d. The network providers who are not accepting new patients.
2. Contractor shall submit the report within fifteen (15) calendar days following the end of the month.

H. Plan Provider Network

Contractor shall submit to DHCS biannually or upon DHCS' request, in a format specified in Exhibit A, Attachment 19, Deliverable Template a report containing the names of all direct subcontracting providers, specialists and provider groups including

FQHCs and RHCs. 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 monthly, no later than fifteen (15) calendar days following the end of the reporting month or within ten (10) calendar days of DHCS' written request.

Regarding the Contractor's provider network responsibilities, the Contractor shall:

1. **Maintain and monitor a network of appropriate providers that is supported by written provider agreements and is sufficient to provide adequate access to all services covered under the contract for all Members, including those with limited English proficiency or physical or mental disabilities.**

2. **Provide for a second opinion from a network provider, or arrange for the Member to obtain a second opinion outside the network, at no cost to the Member.**

3. **If the Contractor's provider network is unable to provide necessary services, covered under the contract, to a particular Member, the Contractor must adequately and timely cover these services out-of-network for the Member, for as long as the Contractor's provider network is unable to provide them.**

4. **Require out-of-network providers to coordinate with the Contractor for payment and ensures the cost to the Member is no greater than it would be if the services were furnished within the network.**

5. **Demonstrate that its network providers are credentialed as required by 42 CFR § 438.214.**

I. 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. **Contractor shall collaborate and participate in DHCS' efforts to promote the delivery of services in a culturally competent manner to all Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity.**

J. Subcontracts

Contractor may enter into subcontracts with other entities in order to fulfill the obligations of the contract. In doing so, Contractor shall meet the subcontracting requirements as stated in 22 CCR 53250, as well as those specified in this contract. Contractor shall

remain accountable for all functions and responsibilities that are delegated to subcontractors.

1. Laws and Regulations

   All subcontracts shall be in writing and in accordance with the requirements of the Health and Safety Code Section 1340 et seq.; 28 CCR 1300.43.12.; Welfare and Institutions Code Section 14200 et seq., **42 CFR § 438.608,** and 22 CCR 53900 et seq.; and applicable Federal and State laws and regulations.

2. Subcontract Requirements

   Each subcontract shall contain:

   a. Specification of the services to be provided by the subcontractor.

   b. Specification that the subcontract shall be governed by and construed in accordance with all laws and applicable regulations governing this contract~~.~~, **including the timely and adequate notice of benefit determinations requirements as identified under Exhibit A, Attachment 7, if such responsibilities are carried out by the Subcontractor.**

   c. Specification of the term of the subcontract, including the beginning and ending dates as well as methods of extension, renegotiation and termination.

   d. Language comparable to Exhibit A, Attachment 10, Provider Compensation Arrangements, Provision H, Non-Contracting Emergency Service Providers for those subcontractors at risk for non-contracting emergency services.

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

   f. 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:

      1) By DHCS, Department of Health and Human Services (DHHS), Department of Justice (DOJ), Department of Managed Health Care (DMHC), **Center for** Medicare and Medicaid Services (CMS), Office of Inspector General **(OIG) and the Office of the Comptroller General, and any other federal or state entities as requested by DHCS.**

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

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

4) For a term of at least ~~five (5)~~**ten (10**) years from the close of the current State 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.

5) Including all encounter and/or claims data for a period of at least ~~five (5)~~**ten (10)** years.

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

h. 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:

1) Make all applicable books and records available at all reasonable times for inspection, examination, or copying by DHCS, DHHS, DOJ, DMHC**, CMS, OIG and the Office of the Comptroller General**.

2) Retain such books and records for a term of at least ~~five (5)~~ **ten (10)** years from the close of the current State 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.

i. Subcontractor's agreement to assist Contractor in the transfer of care pursuant to Exhibit E, Additional Provisions, Provision 17, Phase Out Requirements, in the event of contract termination.

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

k. Subcontractor's agreement to provide written notification to DHCS within thirty (30) calendar days in the event the agreement with the Contractor is amended or terminated. Written notification is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached.

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

m. 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.

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

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

p. Subcontractor's right to submit a grievance and Contractor's formal process to resolve provider grievances**, including federal and state laws, including, but not limited, to CFR § 438.404**.

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

r. If Contractor delegates quality improvement activities, subcontract shall include those provisions stipulated in Exhibit A, Attachment 5, Quality Improvement System, Provision F, Delegation of Quality Improvement Activities.

s. Subcontractor's agreement to comply with all applicable requirements specified in: this Contract and subsequent amendments, Federal and State laws and regulations, and Medi-Cal Dental Managed Care All Plan Letters (APL).

t. 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.

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

3. 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 ten (10) percent of the stock issued by the subcontractor and major creditors holding more than five (5) percent of the debt of the subcontractor will be attached to the subcontract at the time the subcontract is presented to DHCS.

K. Review of Subcontracts

DHCS reserves the right to request and review any subcontracts between the Contractor and the subcontracting party. At the discretion of DHCS, copies of subcontracts and all credentialing or revalidating materials may be requested for review.

L. Subcontracts with Federally Qualified Health Centers, Rural Health Clinics and Indian Health Care Providers ~~Service Facilities~~ (FQHC/RHC/IHCP)

Contractor shall actively conduct outreach to subcontract with Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) and Indian **Care Providers (IHCPs)**~~Service Facilities~~ in the service area and include them as part of the Contractor's provider network.

Subcontracts with FQHCs **and IHCPs** shall also meet subcontract requirements of Provision J above and reimbursement requirements in Exhibit A, Attachment 10, Provider Compensation Arrangements, Provision G. In subcontracts with FQHCs**, IHCPs,** 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. Contractor shall assign Members to FQHCs, RHCs and **IHCPs**~~Indian Health Service Facilities~~.

M. Nondiscrimination in Provider Contracts

Pursuant to 42 CFR 438.12 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.

EXHIBIT A, ATTACHMENT 9
PROVIDER RELATIONS

A. 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.

B. Provider Grievances

Contractor shall have a formal process to accept, acknowledge, and resolve provider ~~grievances~~ **appeals**. A provider of dental services may submit to Contractor a**n** ~~grievance~~ **appeal** concerning the authorization or denial of a service, denial, deferral, or modification of a prior authorization request on behalf of a Member and Contractor shall resolve the ~~grievance~~ **appeal** within thirty (30) calendar days or document reasonable efforts to resolve the ~~grievance~~ **appeal**; 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.

C. 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.

D. Provider Manual

Contractor shall issue a provider manual and updates to the providers of Medi-Cal dental services. The manual and updates shall serve as a source of information to dental providers regarding Medi-Cal dental services, policies and procedures, statutes, regulations, telephone access and special requirements regarding the Medi-Cal Dental Managed Care program.

Contractor is required to inform providers and subcontractors, at the time they enter into a contract, about Member grievance, appeal, and State Fair Hearing procedures and timeframes as specified in 42 CFR 438.400 through 42 CFR 438.424 and described in the Grievance and Appeals section including:

1. Member's right to **request a State Fair Hearing after the Contractor has made a determination on a Member's appeal which is adverse to the Member**;

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

3. Availability of assistance **to the Member with** filing **grievances and appeals**;

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

5. Member's right to request continuation of benefits **that the Contractor seeks to reduce or terminate** during an appeal or State Fair Hearing **filing, if filed within the allowable timeframes, although the Member may be liable for the cost of any continued benefits while the appeal or State Fair Hearing is pending if the final decision is adverse to the Member; and,**

6. All provisions of Exhibit A, Attachment 7, Section B.

E. Provider Training

Contractor shall ensure that all providers receive training regarding the Medi-Cal Dental 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 Dental 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 ten (10) business 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 14, Member Services, including the right to full disclosure of dental care information and the right to actively participate in dental care decisions. Contractor shall ensure that ongoing training is conducted when deemed necessary by either the Contractor or DHCS. **The Contractor must provide all providers and subcontractors specific information in-writing about the grievance and appeal system at the time the Contractor enters into a contract with providers or subcontractors.**

F. 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 dental 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.

EXHIBIT A, ATTACHMENT 10
PROVIDER COMPENSATION ARRANGEMENTS

A. 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.

All providers, FQHCs, RHCs, Indian Health Service Facilities and specialist's compensation arrangements must be submitted to DHCS prior to start of operations. Any additional provider compensation agreements must be submitted to DHCS within thirty (30) days of effective date. DHCS reserves the right to approve or deny any and all compensation arrangements.

If the Contractor puts a provider/physician group at substantial financial risk for services not provided by the provider/physician group, the Contractor must ensure that the provider/physician group has adequate stop-loss protection.

B. Capitation Payments

Capitation payments by a Contractor to a Primary Care Dentist or dental 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 Dentist or dental clinic has been confirmed by the Contractor. However, capitation payments by a Contractor to a Primary Care Dentist or dental clinic for a Member whose assignment to or selection of a Primary Care Dentist or dental 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 thirty (30) calendar days after the Member's enrollment.

C. Provider Incentive Plan

Contractor may develop an incentive program for providers. The incentive program must define performance measures, including a measure for preventive services. Contractor must calculate the incentive based upon the percentage of enrolled Medi-Cal Members (ages 0-under 21) that received services. **Contractor must make available to Members, upon request, any provider incentive plans in place.**

Contractor may only operate a provider incentive plan if no specific payment can be made directly or indirectly under a provider incentive plan to a provider or provider group as an incentive to reduce or limit medically necessary services to a Member. Contractor shall obtain pre-approval to implement the incentive program.

D. Claims Processing

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

1. Contractor shall comply with 42 USC 1396a(a)(37) and Health and Safety Code Sections 1371 through 1371.36. 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.

2. 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.

3. 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.

4. Contractor shall submit claims payment summary reports to DHCS on a quarterly basis as specified in Exhibit A, Attachment 3, Financial Information, Provision B, Financial Audit Reports, Subprovision 5.

E. Prohibited Claims

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.

Contractor must provide that its Members are not held liable for any of the following:

1. Debts of the organization, in the event of the organization's insolvency,

2. Covered services provided to the Member, for which

a. DHCS does not pay the Contractor; or

b. DHCS, or the Contractor, does not pay the individual or health care provider that furnished the services under a contractual, referral, or other arrangement.

3. **Payments for covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the Member would owe if the Contractor covered the services directly.**

F. Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), and Indian Health Care Providers (IHCP)~~Service Facilities~~

1. FQHCs, RHCs, ~~Indian Health Service Facilities~~ **IHCPs** Availability and Reimbursement Requirement

   a. If FQHC, RHC and ~~Indian Health Service Facilities~~ **IHCPs** services are not available in Contractor's provider network or the provider network of another Medi-Cal Dental Managed Care Plan in the service area, Contractor shall reimburse non-contracting FQHCs, RHCs and ~~Indian Health Service Facilities~~ **IHCPs** 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, RHC or ~~Indian Health Service Facilities~~ **IHCPs**. Emergency services rendered by a non-contracting FQHC, RHC or ~~Indian Health Service Facilities~~ **IHCP** shall be reimbursed as specified in Provision G of this Attachment.

   b. If FQHC, RHC or ~~Indian Health Service Facilities~~ **IHCP** services are not available in Contractor's provider network, but are available within any other Medi-Cal Dental Managed Care Plan's provider network in the service area, unless authorized by Contractor, Contractor shall not be obligated to reimburse non-contracting FQHCs~~,~~ **or** RHCs ~~or Indian Health Service Facilities~~ for services provided to Contractor's Members. **If services are provided to Indian Members who are eligible to receive services, Contractor shall reimburse non-contracting IHCP Facilities at a level and amount of payment that is no less than the Contractor makes for the same scope of services furnished by a provider that is not a FQHC, RHC or IHCP.** Emergency services rendered by a non-contracting FQHC, RHC or ~~Indian Health Service Facilities~~ **IHCP** shall be reimbursed as specified in Provision H of this attachment.

   c. **In accordance with 42 CFR 447.56, any Indian Member who is eligible to receive or has received an item or service furnished by an IHCP or through referral under contract health services is exempt from premiums. Indian Members who are currently receiving or have ever received an item or service furnished by an IHCP or through referral under contract health services are exempt from all cost sharing.**

2. Federally Qualified Health Centers/Rural Health Clinics**/Indian Health Care Providers** (FQHC/RHC**/IHCP**) ~~/Indian Health Service Facilities~~

   Contractor shall submit to DHCS, within thirty (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, RHC and **IHCP** ~~Indian Health Service Facilities~~ subcontracts. Contractor shall certify in writing to DHCS within thirty (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, RHC and **IHCP** ~~Indian Health Service Facilities~~ reimbursement to ensure compliance with State and federal law and shall approve all FQHC, RHC and **IHCP** ~~Indian Health Service Facilities~~ subcontracts consistent with the provisions of Welfare and Institutions Code Section 14087.325(h).

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

3. Indian Health **Care Providers (IHCP)**~~Service Facilities~~

Contractor shall reimburse **IHCPs** ~~Indian Health Service Facilities~~ for dental care services provided to Members who are qualified to receive services from an **IHCP** ~~Indian Health Service Facility~~ according to one of the reimbursement options in 22 CCR 55140(a). ~~Contractor shall reimburse non-contracting Indian Health Service Facilities at the approved Medi-Cal per visit rate for that facility.~~ **Contractor shall make payment to IHCPs in a timely manner as required for payments to practitioners in individual or group practices under 42 CFR § 447.45 and 447.46.**

Contractor shall meet the requirements of Medicaid Fee-for-Service (FFS) timely payment for all Indian Tribe, Tribal Organizations, or Indian/Tribal/Urban (I/T/U) Health providers in its network, including the paying of 90 percent of all clean claims from Providers (i.e. those who are in individual or group practice or who practice in shared health facilities) within 30 days of the date of receipt; and paying 99 percent of all clean claims from practitioners (who are in individual or group practice or who practice in shared health facilities) within 90 days of the date of receipt.

Contractor shall pay IHCPs, which are enrolled in Medi-Cal as FQHCs but are not participating providers of the Contractor, an amount equal to the amount the Contractor would pay an FQHC that is a network provider but is not an IHCP, including any supplemental payment from DHCS to make up the difference between the amount the Contractor pays and what the IHCP FQHC would have received under Medi-Cal Fee-for-Service (FFS).

When an IHCP is not enrolled in Medi-Cal as an FQHC, regardless of whether it participates in the network of the Contractor, it has the right to receive its applicable encounter rate published annually in the Federal Register by IHS, or in the absence of a published encounter rate, the amount it would receive if the services were provided under the Medi-Cal state plan's FFS payment methodology.

Contractor shall demonstrate that there are sufficient IHCPs participating in the provider network to ensure timely access to services available under the contract from such providers for Indian Members who are eligible to receive services.

Contractor shall pay IHCPs, whether participating or not, for covered services provided to Indian Members, who are eligible to receive services at a negotiated rate between the Contractor and IHCP or, in the absence of a negotiated rate, at a rate not less than the level and amount of payment the Contractor would make for the services to a participating provider that is not an IHCP.

Indian Members are permitted to obtain covered services from out-of-network IHCPs from whom the Member is otherwise eligible to receive such services. Contractor must permit an out-of-network IHCP to refer an Indian Member to a network provider.

G. Non-Contracting Emergency Service Providers

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 dental condition, including medically necessary dental covered services rendered to a Member to the extent necessary for the Member's condition to be stabilized to sufficiently permit referral in accordance with instructions from Contractor. The non-contracting provider treating the Member's emergency dental condition is responsible for determining the extent of treatment necessary to sufficiently stabilize the Member for referral, 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 provider for dental services at the lowest level of emergency evaluation, unless a higher level is clearly supported by documentation, and for diagnostic services such as radiology. **Absent a separate contract between Contractor and the non-contracting provider stating otherwise, the non-contracting provider must accept as payment in full no more than the amounts (less any payments for indirect costs of medical education and direct costs of graduate medical education) that it could collect if the Member received medical assistance under Fee-For-Service Medi-Cal.**

3. For all non-contracting providers, reimbursement by Contractor, or by a subcontractor who is at risk for out-of-plan emergency dental services, for properly documented claims for services rendered by a non-contracting provider, who is enrolled in the Medi-Cal Dental program (Denti-Cal), pursuant to this Provision shall be made in accordance with Provision D, Claims Processing, above, and 42 USC 1396u-2(b)(2)(D).

4. Contractor shall not refuse to cover reimbursement for emergency dental services rendered by a non-contracting provider based on the provider of emergency services not notifying the Member's Primary Care Dentist or Contractor of the Member's screening and treatment within ten (10) calendar days of presentation for emergency. Contractor shall not limit what constitutes an emergency dental condition solely on the basis of lists of diagnoses or symptoms.

5. Contractor may not deny payment for treatment when a representative of the Contractor instructs the Member to seek emergency services. Contractor may not hold a Member who has an emergency condition liable for subsequent screening and treatment needed to diagnose the specific condition or stabilize the Member.

6. ~~5.~~ 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 thirty (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 thirty (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.

H. Practice Guidelines

1. Contractor must comply with 42 CFR § 438.236, which requires the Contractor to have a Provider Manual, that is inclusive of reliable clinical evidence or a consensus of providers in the particular field, considers the needs of the Contractor's Members, are adopted, in consultation with contracting health care professionals, and reviewed and periodically updated, as appropriate. Following Department approval, the plan shall develop and disseminate the information.

2. Contractor is responsible for the dissemination of the information to all affected providers and, upon request, dissemination to Members and potential Members.

3. Contractor decisions for utilization management, Member education, coverage of services, and other areas to which the Provider Manual applies must be consistent with the Provider Manual.

I. Special contract provisions related to payment. As requested by DHCS, contractor must comply with 42 CFR § 438.6(c).

J. No payments shall be made to a network provider other than by the Contractor for services covered under this contract except when these payments are specifically required to be made by DHCS in Tittle XIX of the Act, in 42 CFR chapter IV, or when DHCS makes direct payments to network providers for graduate medical education costs approved under the State plan.

EXHIBIT A, ATTACHMENT 11
ACCESS AND AVAILABILITY

A. General Requirement

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

Contractor shall ensure Members access to specialists for medically necessary dental covered services. Contractor shall ensure adequate staff within the service area, including dentists, administrative and other support staff directly and/or through subcontracts, sufficient to assure that dental care services will be provided in accordance with this contract and applicable law.

B. Access Requirements

Contractor shall establish acceptable accessibility standards in accordance with 28 CCR 1300.67.2 and as specified below. Contractor shall submit any revisions, updates and/or changes in writing to DHCS within fifteen (15) calendar days of the change. DHCS will review and approve standards for reasonableness. Contractor shall ensure that contracting providers offer hours of operation **that are no less than the hours of operation offered** ~~similar~~ to commercial Members or comparable to Medi-Cal Dental Fee-for-Service (FFS), if the provider serves only Medi-Cal Dental Members. Contractor shall communicate, enforce, and monitor providers' compliance with these standards.

1. Appointments

   Contractor shall implement and maintain procedures for Members to obtain appointments for routine dental care, emergency services, and specialty referral appointments. Contractor shall also include procedures for follow-up on missed appointments.

2. Waiting Times

   Contractor shall develop, implement, and maintain a procedure to monitor waiting times in the provider's offices for scheduled appointments, telephone calls (to answer and return), and time to obtain various types of appointments indicated in Subprovision 1, Appointments, above. The following standards shall apply:

a. Initial Appointment – within 4 weeks

b. Routine Appointment (non-emergency) – within 4 weeks

c. Preventive Dental Care Appointment – within 4 weeks

d. Specialist Appointment – within 30 business days from request **for adult Members, and within 30 calendar days from request for child Members**

e. Emergency Appointment – within 24 hours from the request for appointment

Patient sign-in forms shall be maintained in order to document any time beyond the scheduled appointment time spent by the Member in provider office waiting area.

3. Timely Access

Contractor shall survey, within a year's time, all Primary Care Dentists on the average amount of time it takes for Members to obtain initial appointments, routine appointments, specialist appointments, and emergency appointments. Contractor shall also survey for the number of no show appointments, rescheduled appointments, the availability of interpreter services and an answering service, and the ratio of Members to Primary Care Dentist. Contractor shall submit a Timely Access Report for those Primary Care Dentists surveyed in the reporting quarter in a format specified by DHCS (see Exhibit A, Attachment 20, Deliverable Templates) on a quarterly basis, no later than 30 days after the end of the reporting quarter. **Contractor shall establish mechanisms to ensure compliance by network providers, monitor network providers regularly to determine compliance, and take corrective action in the event that there is a failure to comply by a network provider.**

4. Telephone Procedures

Contractor shall provide 24-hour a day telephone access for Members to Primary Care Dentists, emergency services, and specialists, including access to telephone interpreters.

5. Specialty Services

Contractor shall arrange for the provision of specialty services from specialists outside the network if unavailable within Contractor's network, when it is determined to be medically necessary dental covered services.

Contractor shall submit a Specialty Referral Report in a format specified by DHCS (see Exhibit A, Attachment 20, Deliverable Templates) on a biannual basis, no later than January 31st and July 31st of each calendar year that shows how many referrals were made per month to specialists with the detail for each referral, timeliness of receipt and review, and the result of each referral.

C. 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. **Should the Contractor elect not to provide, reimburse for, or provide coverage of, a counseling or referral service, the Contract must furnish information about the services it does not cover to DHCS whenever it adopts such a policy during the term of the contract.**

D. Emergency Care

Contractor shall ensure that a Member with an emergency dental 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.

Contractor shall cover emergency dental services without prior authorization pursuant to 22 CCR 53216 and 28 CCR 1300.67(g).

E. 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 sixty (60) calendar 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.

F. 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.

G. 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.

H. Linguistic Services

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

2. Contractor shall comply with 42 CFR 438.10(c) **and 438.10(d)** and ensure that all monolingual, non-English-speaking, or limited English proficient (LEP) Medi-Cal beneficiaries receive 24-hour interpreter services at all key points of contact, as defined in Subprovision 3 of this Provision, either through interpreters or telephone language services.

3. **In accordance with 42 CFR 438.10(d),** Contractor shall provide, at minimum, the following linguistic services at no cost to Medi-Cal Members:

   a. Interpreters, signers, or bilingual providers and provider staff at all key points of contact. These services shall be provided to all Members and not limited to those that speak the threshold or concentration standards languages.

   b. Fully translated written informing materials, including but not limited to the **Provider Directories,** Member services guide, **Member** ~~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. **Contractor must make its written materials that are critical to obtaining services, including, at a minimum, provider directories, Member handbooks, appeal and grievance notices, and denial and termination notices, available in the prevalent non-English (also referred to as threshold or concentration) languages in its particular service area.**

   c. Referrals to culturally and linguistically appropriate community service programs. **Contractor shall have methods to promote access and delivery of services in a culturally competent manner to beneficiaries, including those with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity. These methods shall ensure that beneficiaries have access to covered services as prescribed in Exhibit A, Attachment 12, that are delivered in a manner that meets their unique needs, including, but not limited to, sexual orientation or gender identity.**

d. **Contractor must make written materials available in alternative formats upon request of the potential Member or Member at no cost. Auxiliary aids and services must also be made available upon request of the potential Member or Member at no cost. Written materials must include taglines in the prevalent non-English languages in the state, as well as large print, explaining the availability of written translation or oral interpretation to understand the information provided and the toll-free and TTY/TDY telephone number of the Contractor's member/customer service unit. Large print means printed in a font size no smaller than 18 point. Contractor must make interpretation services available free of charge to each Member. This includes oral interpretation and the use of auxiliary aids such as TTY/TDY and American Sign Language. Oral interpretation requirements apply to all non-English languages, not just those that the State identifies as prevalent.**

e. **Contractor must notify its Members:**

1) **That oral interpretation is available for any language and written translation is available in prevalent languages;**
2) **That auxiliary aids and services are available upon request and at no cost for Members with disabilities; and**
3) **How to access the services in paragraphs (d)(5)(i) and (ii) of this section.**

f. **Contractor must provide all written materials for potential Members and Members consistent with the following:**

1) **Use easily understood language and format.**
2) **Use a font size no smaller than 12 point.**
3) **Be available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of Members and Members with disabilities or limited English proficiency.**
4) **Include a large print tagline and information on how to request auxiliary aids and services, including the provision of the materials in alternative formats. Large print means printed in a font size no smaller than 18 point.**

g. ~~d.~~ 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.

h~~e~~. 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.

4. Contractor shall provide translated materials to the following population groups within its service area as determined by DHCS:

   a. 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.

   b. A population group of mandatory Medi-Cal beneficiaries residing in the service area who indicate their primary language as other than English and who meet the concentration standards of 1,000 in a single ZIP code or 1,500 in two contiguous ZIP codes.

5. Key points of contact include:

   a. Dental care settings: telephone, advice and urgent care transactions, and encounters with dental care providers including pharmacists.

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

I. Section 1557 of the Patient Protection and Affordable Care Act

1. Section 1557 of the Patient Protection and Affordable Care Act prohibits discrimination against individuals participating in certain health programs or activities based on race, color, national origin, sex, age, or disability. This anti-discrimination clause extends to:

a. Any health program or activity any part of which receives funding from HHS;

b. Any health program or activity that HHS administers;

c. Health Insurance Marketplaces and all plans offered by issuers that participate in those Marketplaces.

Contractor agrees to be responsible for ensuring that the Contractor, any subcontractors, and providers comply with the non-discrimination clauses.

J. Anti-Discrimination against Gender Identity and Sexual Orientation

Contractor shall ensure its enrollment practices are non-discriminatory in regards to race, color, national origin, sex, sexual orientation, gender identity, or disability. Any policy or practice that has the effect of discriminating based race, color, national origin, sex, sexual orientation, gender identity or disability is federally prohibited.

K. Voluntary Enrollment

Enrollment is voluntary, except in the case of mandatory enrollment programs. The entities must accept individuals eligible for enrollment in the order in which they apply without restriction (unless authorized by CMS), up to the limits set under the contract.

L~~I~~. 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 **Members** ~~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. Contractor shall submit disaster recovery policies and procedures to DHCS no later than thirty (30) calendar days after contract execution for review and approval. Contractor shall submit any revisions, updates and/or changes in writing to DHCS for approval fifteen (15) calendar days prior to implementing the proposed revision, update and/or change.

EXHIBIT A, ATTACHMENT 12
SCOPE OF SERVICES

A. Covered Services

Contractor shall provide or arrange for Members all medically necessary dental covered services and other services required in this contract**, in addition to providing assistance to Members as part of the Beneficiary Support System**. Covered services are those services set forth in Welfare and Institutions Code Section 14132(h), 22 CCR 51059, 51307, and 51003, **and the Denti-Cal Manual of Criteria,** unless otherwise specifically excluded under the terms of this contract. ~~Frequency limitations identified may be exceeded based on dental necessity and appropriateness of care, but in no case shall the frequency limitations be more restrictive.~~ **Services shall be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to Members under FFS Medi-Cal.** Contractor shall not arbitrarily deny or reduce the amount, duration, or scope of a required dental service solely because of diagnosis, type of illness, or condition of the beneficiary**, and services should be provided in accordance with the Denti-Cal Manual of Criteria**. **Contractor is allowed to place appropriate limits on a service for the purpose of utilization control, provided the services furnished can reasonably achieve their purpose.**

B. Medically Necessary Dental Covered Services

For purposes of this Contract, the term "medically necessary dental covered services" will include all covered services, as identified in the Medi-Cal Dental Manual of Criteria, 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 **as set forth in** 22 CCR 51303(a)**. Contractor is responsible for covering services related to the ability for a Member to achieve age-appropriate growth and development, and to attain, maintain, or regain functional capacity. "Medically necessary services" shall be no more restrictive than services provided under FFS Medi-Cal, including quantitative and non-quantitative treatment limits, as indicated in state statutes and regulations, the State Plan, and other State policies and procedures.**

When determining the medical necessity of dental 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.

C. Services for Members under 21 Years of Age

Contractor shall ensure the provision of Early and Periodic Screening, Diagnos~~is~~**tic,** and Treatment (EPSDT) services ~~and EPSDT Supplemental dental services~~ for Members under **21 years of age**~~the age of 21~~. **EPSDT services include the following:**

1) **Dental services which are provided at intervals which meet reasonable standards of dental practice including the American Academy of Pediatric Dentistry periodicity schedule for dental services for children.**

2) **Dental services at other such intervals, as medically necessary, to determine the existence of a suspected illness or condition.**

3) **Dental services that include relief of pain and infections, restoration of teeth, and maintenance of dental health.**

For Members under 21 years of age, a service is "medically necessary" if the service meets standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code. Medically necessary dental services shall include diagnostic services, treatment, and other measures to correct or ameliorate defects and physical and mental illness and conditions discovered by screening services, whether or not such services are a covered benefit. Contractor shall ensure any Member materials related to the coverage of EPSDT services accurately reflect this medical necessity standard.

~~Contractor shall inform Members that EPSDT services are available for Members under 21 years of age, provide comprehensive dental screening and prevention services, and provide treatment for all medically necessary dental covered services. Contractor shall also adopt the American Academy of Pediatric Dentistry periodicity schedule for dental services to children, including first visit by first birthday.~~

~~For Members under the age of 21 and in those cases where a provider requests EPSDT supplemental dental services pursuant to 22 CCR 51340 and 51340.1, Contractor shall forward all such requests and associated case documentation to DHCS for review by a DHCS Dental Program Consultant.~~

Contractor at a minimum shall be required to:

1) Include relevant language on EPSDT ~~supplemental~~ service**s** from the Denti-Cal provider Handbook in the plan' provider manuals;

2) Provide specific training on EPSDT ~~supplemental~~ services to plans' provider network;

3) Describe the process to review EPSDT requests, including how the provider and Member will be notified of their disposition.

D. Services for All Members

1. Health Education

   a. Contractor shall implement and maintain a dental health education system that provides the organized programs, services, functions, and resources necessary to deliver dental health education to assist Members to improve their dental health and manage dental disease.

b. Contractor shall ensure the organized delivery of dental 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 dental health. Contractor shall ensure that all dental 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.

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

d. Contractor shall ensure that Members receive dental health education services as part of preventive services and primary dental health care visits. Contractor shall provide resource information, educational materials and other program resources to assist providers to provide effective dental health education services for Members. Contractor is responsible to assist Primary Care Dentists 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.

e. Contractor shall adopt and maintain appropriate dental health education program standards/guidelines and policies/procedures. Contractor shall maintain documentation that demonstrates effective implementation of all DHCS health education requirements under this contract.

f. Contractor shall monitor the performance of subcontractors that deliver dental health education programs and services to Members, and implement strategies to improve performance and effectiveness.

g. No later than thirty (30) calendar days after the beginning of each calendar year, Contractor shall submit to DHCS documentation on the Contractor's health education programs and services and all materials related to health education for review and approval.

EXHIBIT A, ATTACHMENT 13
CASE MANAGEMENT AND COORDINATION OF CARE

A. Case Management Services

Contractor shall provide dental 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 dental covered services delivered both within and outside the Contractor's provider network.

Each Contractor must implement procedures to deliver care to and coordinate services for all Members. These procedures must meet DHCS requirements and must do the following:

1. **Ensure that each Member has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the Member. The Member must be provided information on how to contact their designated person or entity; and**

2. **Coordinate the services the Contractor furnishes to the Member:**
   a. **Between settings of care;**
   b. **With the services the Member receives from any other Medi-Cal managed care plan, including both medical and dental managed care;**
   c. **With the services the Member receives in Medi-Cal Fee-for-Service delivery systems; and**
   d. **With the services the Member receives from community and social support providers.**

Contractor shall submit and implement a DHCS approved transition of care policy for individuals transitioning to managed care from FFS, or from one MCO to another, when a Member without continued services would experience serious detriment to their health or put them at risk of hospitalization or institutionalization. Transition policies must be consistent with the requirements in 42 CFR § 438.62(b)(1).

In accordance with 42 CFR § 438.208(b)(5), the Contractor must ensure that each provider furnishing services to Members maintains and shares as appropriate a Member health record in accordance with professional standards.

Contractor shall develop and implement an initial dental health assessment appointment policy that may be fulfilled by an initial appointment with the Member's primary care dentist. This appointment shall be a separate and distinct requirement from the initial health screening policy decribed in Section C of this Attachment.

B. 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 to ensure coordinated service delivery and efficient and effective joint case management for services presented in Provisions C and D below.

C. Initial Health Screening Requirement

1. **Contractor shall develop and implement an initial health screening policy, and conduct an initial screening of each new Member using an oral health information form (OHIF), in accordance with 42 CFR § 438.208 (b) and any related APLs issued by DHCS. Consistent with the federal requirement, the Contractor shall submit to DHCS any changes to their initial screening policy within ten (10) calendar days of any changes, and annually no later than thirty (30) days after the first day of every calendar year.**

2. **Contractor shall make a best effort to conduct an initial screening of each Member's needs, within 90 days of the effective date of enrollment for all new Members, including subsequent attempts if the initial attempt to contact the Member is unsuccessful.**

3. **Contractor shall share with DHCS or other Contractors serving the member the results of any identification and assessment of that Member's needs to prevent duplication of those activities.**

D. Services for Members with Special Health Care Needs

Members with Special Health Care Needs (SHCN) are defined as those who have or are at increased risk for a chronic physical, behavioral, developmental, or emotional conditions and who also require health or related services of a type or amount beyond that required by Members generally. Contractor shall have in

place a SHCN policy in accordance with 42 CFR § 438.208 (c) and any related APLs issued by DHCS.

1. Contractor shall implement mechanisms to comprehensively assess each Member identified as having SHCN, to identify any ongoing special conditions of the Member that require a course of treatment or regular care monitoring.

2. For Members with SHCN that are determined by assessment to need a course of treatment or regular care monitoring, the Contractor shall produce a treatment or service plan that meets the following criteria:

   a. Approved by the Contractor in a timely manner, if approval is required by the Contractor;

   b. In accordance with any applicable DHCS quality assurance and utilization review standards; and

   c. Reviewed and revised upon reassessment of functional need, at least every 12 months, or when the Member's circumstances or needs change significantly or at the request of the Member per 42 CFR §441.301(c)(3).

3. Contractor must have a mechanism in place to allow Members to directly access a specialist as appropriate for the Member's condition and identified needs.

E.~~C.~~ 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:

~~1.~~ **a.** Standardized procedures that include dental care provider training for the identification of CSHCN, at enrollment and on a periodic basis thereafter. The identification, assessment, treatment, and coordination of care for CSHCN shall comply with the requirements of 42 CFR 438.208(b)(3) ~~and~~ (b)(4) and 438.208(c)(2), (c)(3), and (c)(4).

~~2.~~ **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 Dentist, standing referrals, or other methods as defined by Contractor.

~~3.~~ **c.** Methods for ensuring that each CSHCN receives a comprehensive oral assessment and development of a written dental treatment plan.

~~4.~~ **d.** Case management or care coordination for CSHCN, including coordination with the child's medical managed care plan for surgicenter or hospital operating room support services for dental services, and with other agencies which provide services for children with special health care needs (e.g. mental health,

substance abuse, Regional Center, CCS, local education agency, child welfare agency);

~~5.~~ **e.** Methods for monitoring and improving the quality and appropriateness of care for CSHCN.

F. ~~D.~~ California Children's 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.

1. 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:

   a. Assure that contracting providers are informed about CCS-paneled providers within Contractor's network, and procedures that provide for continuity of care between the contracting providers and CCS providers for CCS-covered conditions.

   b. Ensure that Contractor continues to provide all medically necessary dental covered services for the Member's CCS eligible condition until CCS eligibility is confirmed.

   c. Ensure that, once eligibility for the CCS program is established for a Member, Contractor shall continue to provide all medically necessary dental covered services that are unrelated to the CCS eligible condition and shall monitor and ensure the coordination of services between its Primary Care Dentist, the CCS specialty providers, and the local CCS program.

G. ~~E.~~ Provider-Preventable Condition (PPC) Requirements

1. **Contractor must comply with 42 CFR § 438.3, which mandates that Contractor require provider identification of PPCs as a condition precedent of payment, as well as the prohibition against payment for PPCs as set forth in 42 CFR § 434.6(a)(12) and 42 CFR § 447.26.**

2. **Contractor must report all identified PPCs in a form and frequency as specified by DHCS. In order to inform Medi-Cal providers of the latest developments concerning PPC requirements, DHCS has created a one-stop website with current information and links to PPC documents, including the updated PPC reporting form: http://www.dhcs.ca.gov/individuals/Pages/AI_PPC.aspx or as updated by DHCS.**

3. Reporting is mandatory under federal law pursuant to 42 CFR § 434.6(a)(12) and 42 CFR § 447.26. A provider must report the occurrence of any PPC in any Medi-Cal patient that did not exist prior to the provider initiating treatment, regardless of whether the provider seeks Medi-Cal reimbursement for services to treat the PPC.

4. A provider shall report any PPC in the manner prescribed by DHCS, which includes completing and submitting the PPC Reporting Form (DHCS 7107). An electronic copy shall be submitted, concurrent to the reporting, to: dmcdeliverables@dhcs.ca.gov, or as updated by DHCS to Contractor through a Dental All Plan letter.

5. Providers must submit the form within five days of discovering the condition and confirming that the patient is a Medi-Cal beneficiary.

6. The contract prohibits the Contractor from making payment to a provider for Provider-Preventable Conditions. Provider-Preventable Condition means a condition occurring in any health care setting that meets the following criteria:

   a. Is identified in the State plan.

   b. Has been found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines.

   c. Has a negative consequence for the beneficiary.

   d. Is auditable.

   e. Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

H. Services That May Be Covered By the Contractor

1. A Contractor may cover, for Members, services or settings that are in lieu of services or settings covered under the State plan as follows:

   a. DHCS determines that the alternative service or setting is a medically appropriate and cost effective substitute for the covered service or setting under the State plan.

   b. The Member is not required by the Contractor to use the alternative service or setting.

c. **The approved in lieu of services are authorized and identified in the Contractors contract, and will be offered to enrollees at the option of the Contractor.**

EXHIBIT A, ATTACHMENT 14
MEMBER SERVICES AND BENEFICIARY SUPPORT

A. Members Rights and Responsibilities

1. 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 and providers. **Contractor must comply with any applicable Federal and state laws that pertain to Member rights and ensure that its employees and contracted providers observe and protect those rights.**

a. Contractor's written policies regarding Member rights shall include the following:

~~1)~~ 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 and dental information.
~~2)~~ to be provided with information about the plan and its services, including covered services, as identified in the Medi-Cal Dental Manual of Criteria.
~~3)~~ to be able to choose a Primary Care Dentist within the Contractor's network.
~~4)~~ to participate in decision making regarding their own dental care, including the right to refuse treatment**, and to express preferences about future treatment decisions**.
~~5)~~ to ~~voice~~**file a** grievance~~s~~, either verbally or in writing, ~~about the organization or the care received.~~**about any matter other than an adverse benefit determination, which may include, but is not limited to, the quality of care or services provided, aspects of interpersonal relationships between a provider and a Member, such as offensive behavior on part of a provider or an employee, failure to respect the Member's rights regardless of whether remedial action is requested, and to dispute an extension of time proposed by the Contractor to make an authorization decision.**
6) to have access to the Contractor's grievance and appeal system, according to Exhibit A, Attachment 15.
7) to request an appeal, which the Contractor shall review, if an adverse benefit determination is received concerning:
  a) the denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
  b) the reduction, suspension, or termination of a previously authorized service;
  c) the denial, in whole or in part, of payment for a service;
  d) the failure to provide services in a timely manner, as defined by the State;

e) the failure of the contractor to act within timeframes defined by the State regarding the standard resolution of grievances and appeals;
f) or the denial of a request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities.

8) to have the notice of adverse benefit determination explain reasons for the adverse benefit determination, including the right of the Member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Member's adverse benefit determination.
9) to receive standard resolution of an appeal and notice to the affected parties no later than thirty calendar days from the day the Contractor receives the appeal.
10) to receive Member notices and state hearing policies covered in Exhibit A, Attachment 15.
11) to request a State fair hearing only after the Member exhausts the appeals process and receives notice that the Contractor is upholding an adverse benefit determination.
12) to initiate a State fair hearing if the Contractor fails to adhere to notice and timing requirements, and the Member has exhausted the appeals process. Written notice of the resolution of a grievance or an appeal must meet format and language requirements specified by the State.
13) to have the State offer and arrange for an external medical review if the following conditions are met:
    a) the review must be at the Member's option and must not be required before or used as a deterrent to proceeding to the State fair hearing;
    b) the review must be independent of both the State the Contractor;
    c) the review must be offered without any cost to the Member;
    d) the review must not extend any of the timeframes above and must not disrupt continuation of benefits.
14) to identify that if the Contractor, or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Contractor must authorize or provide the disputed services promptly and as expeditiously as the Member's health condition requires, but no later than 72 hours from the date it receives notice reversing the determination.
15) to identify that for services furnished while the appeal is pending, if the Contractor, or the State fair hearing officer reverses a decision to deny authorization of services, and the Member received the disputed services while the appeal was pending, the Contractor, or the State, must pay for those services, in accordance with State policy and regulations.
16) to continue benefits while the Contractor appeal and the state fair hearing are pending. Timely filing of a state hearing occurs within 10

calendar days of the contractor sending the notice of adverse benefit determination or on or before the intended effective date of the contractor's proposed adverse benefit determination.

17) to request reinstatement of the Member's benefits, while the appeal or state fair hearing is pending. The benefits must be continued until one of the following occurs:

1. **the Member withdraws the appeal or request for state fair hearing;**
2. **the Member fails to request a state fair hearing and continuation of benefits within 10 calendar days after the contractor sends the notice of an adverse resolution to the Member's appeal;**
3. **a State fair hearing office issues a hearing decision adverse to the Member.**

18) to be notified that when the resolution of an appeal or state fair hearing is adverse to the Member, that is the Contractor's adverse benefit determination is upheld, the Member is subject to cost recovery by the Contractor consistent with 42 CFR § 431.230(b), for those services furnished to the Member while the appeal and state fair hearing was pending.

~~6)~~ **19)** to receive interpretation services for their language.

~~7)~~ **20)** to have access to all medically necessary dental service provided in Federally Qualified Health Centers, Rural Health Clinics or Indian Health **Care Providers**~~Service Facilities~~, and access to emergency dental services outside the Contractor's network pursuant to federal law.

~~8)~~ **21)** to request a State Medi-Cal fair hearing, including information on the circumstances under which an expedited fair hearing is possible**, after completion of the appeals process as in 5) above**.

~~9)~~ **22)** to have access to, and where legally appropriate, receive copies of, amend or correct their dental record.

~~10)~~ **23)** ~~todisenroll upon request.~~ **to be provided disenrollment requirements and limitations including information about procedures, timeframes, notices, grievances and State fair hearings related to, and reasons for which:**

- **a) the Contractor may request disenrollment**
- **b) the Contractor is prohibited from requesting disenrollment, such as an adverse change in the Member's health status, or because of the Member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the plan seriously impairs the Contractor's ability to furnish services to either this particular Member or other Members).**
- **c) the Member may request disenrollment, for cause, at any time.**
  - **i. causes for disenrollment include:**
    - **(a) the Member moves out of the Contractor's service area.**
    - **(b) the Member needs related services to be performed at the same time; not all related services are available within the**

provider network; and the Member's primary care provider or another provider determines that receiving the services separately would subject the Member to unnecessary risk.

(c) other reasons, including poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the ~~enrollee~~ Member's care needs.

ii. without cause, at the following times:

(a) during the 90 days following the date of the beneficiary's initial enrollment into the plan, or during the 90 days following the date the State sends the beneficiary notice of that enrollment, whichever is later.

(b) at least once every 12 months thereafter.

(c) upon automatic reenrollment under paragraph (g) of this section, if the temporary loss of Medicaid eligibility has caused the beneficiary to miss the annual disenrollment opportunity.

(d) when the State imposes the intermediate sanction specified in § 438.702(a)(4).

~~11)~~ **24)** 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.

~~12)~~ **25)** to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

~~13)~~ **26)** to receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand.

~~14)~~ **27)** freedom to exercise these rights without adversely affecting how they are treated by the Contractor, providers, or the State.

~~15)~~ **28)** to have access to Contractor's health education programs and outreach services in order to improve dental health.

~~16)~~ **29)** to request a second opinion, including from a specialist at no cost.

30) to be free from the Contractor prohibiting, or otherwise restricting, a provider acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is his or her patient, for the following:

a) the Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

b) any information the Member needs to decide among all relevant treatment options.

c) the risks, benefits, and consequences of treatment or non-treatment.

31) to be provided information about definitions of emergency care and how to access emergency dental treatment, and rules for coverage regardless of whether the provider that furnishes the services has a contract with the Contractor, under payment rules governed by Title XIX of the Act and the States.

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

B. Member Services Staff

1. Contractor shall maintain the level of knowledgeable and trained staff sufficient to provide covered services to Members and all other services covered under this contract.

2. Contractor shall ensure Member services staff are trained on all contractually required Member service functions including, policies, procedures, and scope of benefits of this contract.

3. 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.

4. Contractor shall ensure that Member Services staff will refer potential Members to the DHCS enrollment broker when potential Members make a request for enrollment with Contractor.

5. Contractor shall conduct phone calls to Members who have not seen their Primary Care Dentist in the last 12 months. Contractor shall ensure that Members are set up with an appointment, if requested, and Members understand their rights to access to care and services. Contractor shall report the results to DHCS no later than thirty (30) calendar days following the end of the reporting month.

6. Contractor shall ensure that the average wait time during business hours for a Member to speak by telephone with Member services staff does not exceed ten minutes, in accordance with 28 CCR 1300.67.2.2(c)(10).

C. Call Center Reports

Contractor shall report biannually, no later than January 31st and July 31st of each calendar year, in a format outlined in Exhibit, A, Attachment 20, Deliverable Templates, the number of calls received by call type (questions, grievances, access to services, request for dental health education, etc.); the average speed to answer Member services telephone calls with a live voice; and the Member services telephone calls abandonment rate.

Contractor must maintain a weekly average "P" factor of no more than seven (7) percent. "P' factor is defined as the percentage of connected calls versus non-connected calls and/or busy signals.

D. Written Member Information

1. Contractor shall provide all new Members, and potential enrollees on request only, with written Member information as specified in 22 CCR 53926.5. **Contractor is required to use State Developed Model Enrollee Handbook.** 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, dental health education. **Contractor shall provide each enrollee an enrollee handbook, which serves as a summary of benefits and coverage, within a reasonable time after receiving notice of the beneficiary's enrollment.**

2. Contractor shall distribute the Member information no later than seven (7) calendar days following enrollment. Contractor shall distribute Member information annually to each Member or family unit.

    1. **Distribution of Member Information shall be considered provided after Contractor completes one of the following:**

        a. **Mails a printed copy of the information to the enrollee's mailing address.**
        b. **Provides the information by email after obtaining the enrollee's agreement to receive the information by email.**
        c. **Posts the information on its website and advises the enrollee in paper or electronic form that the information is available on the Internet and includes the applicable Internet address provided that enrollees with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost.**
        d. **Provides the information by any other method that can reasonably be expected to result in the enrollee receiving the information.**

3. Contractor shall ensure that all written Member information is provided to Members at a sixth (6^{th}) grade reading level. The written Member information shall ensure Members' understanding of the covered services, processes and ensure the Member's ability to make informed dental health decisions.

    Written Member-informing materials shall be translated into the identified threshold and concentration languages discussed in Exhibit A, Attachment 11, Access and Availability, Provision H, Linguistic Services.

    Written Member informing materials shall be provided in alternative formats (including Braille, large size print, and 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.

4. **In accordance with 42 CFR 438.10 (c)(6), if the Contractor chooses to provide the required information electronically to Members, it must be: in a format that is readily accessible; in a location on the Contractor's website that is prominent and readily accessible; and provided in an electronic form which can be electronically retained and printed. The information must be consistent with content and language requirements of 42 CFR 438.10 and Attachment 14. In addition, Contractor must notify Members that the information provided electronically is available in paper form without charge upon request, and Contractor must provide it to Members upon request within 5 business days.**

5~~4~~. The Member services guide shall be submitted to DHCS annually no later than thirty (30) calendar days after the beginning of each calendar year 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) 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; (a), as to print size, readability, and understandability of text, and shall include the following information:

a. The plan name, address, telephone number and service area covered by the dental health plan.

b. A description of the full scope of Medi-Cal Dental Managed Care covered benefits and all available services including dental health education as prescribed in Exhibit A, Attachment 12, Scope of Services, Provision D, Services for All Members, 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.

c. Procedures for accessing covered services including that covered services shall be obtained through the plan's providers unless otherwise allowed under this contract.

   Include 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.

d. Compliance with the following may be met through distribution of a provider directory:

   The address and telephone number of each service location (e.g., locations of hospitals, Primary Care Dentists (PCD), Federally Qualified Health Centers (FQHC), Rural Health Clinics **(RHC)** and Indian Health ~~Service Facilities~~**Care Providers (IHCP)**).

The hours and days when each of these facilities is open, the services and benefits available to include but not limited to: the telephone number to call after normal business hours, the languages spoken, whether the office will see children 0-3, pregnant women and children with special health care needs.

Further, Contractor must make available in paper form upon request and electronic form, the following information about its network providers:

1) **The provider's name as well as any group affiliation.**
2) **Street address (es).**
3) **Telephone number(s).**
4) **Web site URL, as appropriate.**
5) **Specialty, as appropriate.**
6) **Whether the provider will accept new Members.**
7) **The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training.**
8) **Whether the provider's office/ facility has accommodations for people with physical disabilities, including offices, exam room(s) and equipment.**

The provider directory must include the information in the paragraph above for each of the provider types covered under the contract.

Information included in a paper provider directory must be updated at least monthly and electronic provider directories must be updated no later than 30 calendar days after the Contractor receives updated provider information.

Provider directories must be made available on the Contractor's Web site in a machine readable file and format as specified by federal regulation.

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

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

g. The appropriate use of dental care services in a managed care system.

h. 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.

i. Procedures for obtaining emergency dental care from specified plan providers or from non-plan providers, including outside Contractor's service area.

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

k. Procedures for obtaining any transportation services to service locations 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.

l. Procedures for **requesting an appeal or** filing a grievance with Contractor, either verbally or in writing, including procedures for appealing decisions regarding Member's coverage **or**~~,~~ benefits, or **filing grievances about a** relationship to the organization or other dissatisfaction with the Contractor and/or providers. Include the title, address, and telephone number of the person responsible for processing and resolving **appeals and** grievances and responsible for providing assistance with completing the request. Information regarding the process shall include the requirements and the timelines for the Contractor to acknowledge receipt of **and** ~~grievances, to~~ resolve **appeals and** 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 **appeal or** grievance is being resolved.

m. The causes for which a Member shall lose entitlement to receive services under this Contract as stipulated in Exhibit A, Attachment 16, Enrollments and Disenrollments, Provision D, Disenrollment.

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

o. Information on the Member's right to ~~the Medi-Cal fair hearing process including information on the circumstances under which an expedited 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 dental care service requested by the Member or provider has been denied, deferred or modified.~~ **submit a request for an appeal following an adverse benefit determination or to file a grievance for issues other than adverse benefit determinations, including timelines and information about how a Member may request a State fair hearing after exhausting the appeals process and receiving notice that the Contractor is upholding an adverse benefit determination.** 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 hearing.

p. Information on the availability of, and procedures for obtaining, services at Federally Qualified Health Centers, Rural Health Clinics and Indian Health **Care Providers** ~~Service Facilities~~.

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

r. 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 (1-888-466-2219).

s. 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.

t. 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; and Members already enrolled in another Medi-Cal, Medicare or commercial managed care plan.

u. An explanation of an American Indian Member's right not to be restricted in their access to **Indian Health Care Providers (IHCP)**~~Indian Health Service facilities~~ by Contractor, and to disenroll from Contractor's plan at any time, without cause.

v. Any other information determined by DHCS to be essential for the proper receipt of covered services.

6. 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.

7. Annual Member Reminder

During the Member's enrollment anniversary month, the Contractor shall provide a maximum one page information guide to each Member annually. The guide shall include the Member's PCD's name, address, phone number, and operating hours as well as the Member Service's phone number. The guide should also include, but not be limited to information regarding benefits, PCD changes, and problems accessing services. Contractor shall submit for review and approval a sample of the guide to DHCS no later than thirty (30) calendar days after the beginning of each calendar year.

E. Member Notification of Changes in Access to Covered Services

1. Contractor shall ensure Members are notified in writing of any changes in the availability or location of covered services, or any other **changes to the Enrollee Handbook or information listed in** 42 CFR 438.10(~~f~~g)(4) **that DHCS defines as significant**, at least thirty (30) calendar days prior to the effective date of such changes. In the event of a ~~natural disaster or~~ emergency **or other unforeseeable circumstances**, Contractor shall provide notice **of the emergency or other unforeseeable circumstance to DHCS** ~~to Members~~ as soon as possible, but no later than fourteen (14) calendar days. The notification to Members must be presented to and approved in writing by DHCS prior to its release.

2. **Pursuant to 42 CFR 438.10(f)(1), Contractor must make a good faith effort to give written notice of termination of a contracted provider, within 15 calendar days after receipt or issuance of the termination notice, to each Member who received his or her primary dental care from, or was seen on a regular basis by, the terminated provider.**

~~3. a. Contractor is subject to the information requirements of paragraph (b) of this section, a Contractor that would otherwise be required to provide, reimburse for, or provide coverage of, a counseling or referral service because of the requirement in 42 CFR 438.102 (a)(1) is not required to do so if the Contractor objects to the service on moral or religious grounds.~~

~~b. Information requirements: The Contractor's responsibility. A Contractor that elects the option provided in paragraph (a) of this section must furnish information about the services it does not cover as follows:~~

~~1)To DHCS—~~

~~a)With its application for a Medi-Cal contract.~~

~~b)Whenever it adopts the policy during the term of the contract.~~

~~2)Consistent with the provisions of § 438.10, to Members, within 90 days after adopting the policy for any particular service.~~

~~a)Although this timeframe would be sufficient to entitle the Contractor to the option provided in paragraph (a) of this section, the overriding rule in § 438.10(g)(4) requires the State, its contracted representative, to furnish the information at least 30 days before the effective date of the policy.~~

3. **Contractor shall not be required to provide, reimburse for, or provide coverage of, a counseling or referral service that would otherwise be required under 42 CFR 438.102(a)(1) if Contractor objects to the service on moral or religious grounds. If Contractor elects to exercise this option, the following requirements must be met:**

   a. **Contractor must furnish information about the services it does not cover to DHCS with its application for a Medi-Cal contract and whenever it adopts the policy during the term of the contract.**

b. Contractor must furnish information about the service it does not cover to Members at least 30 days before the effective date of the policy consistent with 42 CFR 438.10(g)(4).

F. Primary Care Dentist Selection

1. Contractor shall implement and maintain DHCS approved procedures to ensure that each new Member has an appropriate and available PCD. Contractor shall ensure that Members are allowed to change a PCD, upon request, by selecting a different Primary Care Dentist from Contractor's network of providers.

2. **Contractor shall permit any Indian Member, if eligible to receive services from an IHCP primary care dentist, to choose that ICHP as his or her primary care dentist as long as that provider has capacity to provide the services.**

3. Contractor shall disclose to affected Members any reasons that their selection or change in PCD could not be made.

4. 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.

G. Primary Care Dentist Assignment

1. If the Member does not select a Primary Care Dentist within thirty (30) calendar days of the effective date of enrollment, Contractor shall assign that Member to a Primary Care Dentist and notify the Member and the assigned Primary Care Dentist no later than forty (40) calendar days after the Member's enrollment. When assigning a Primary Care Dentist to a Member, the Contractor must take into consideration the age, location and linguistics of the Member and provider. The Contractor shall ensure that adverse selection does not occur during the assignment process of Members to Primary Care dentists. If, at any time, a Member notifies the Contractor of a primary care dentist or subcontracting dental plan choice, such choice shall override the Member assignment to a Primary Care Dentist or subcontracting dental plan.

2. Contractor shall notify the Primary Care Dentist that a Member has selected or been assigned to the provider within ten (10) calendar days from when selection or assignment is completed by the Member or the Contractor, respectively. The Contractor shall provide to the PCD the address, phone number and all contact information the plan has on the Member.

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

1. 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 dental 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.

2. 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:

   a. The Member's right to, method of obtaining, and time limit for requesting a State Fair Hearing **after exhausting the appeal process,** 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.

   b. The Member's right to represent himself/herself at the fair hearing or to be represented by legal counsel, friend or other spokesperson.

   c. 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.

3. Contractor shall provide required notification to Members 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 (3rd)~~second business day after the decision is made, not to exceed fourteen (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 7, Utilization Management, Provision C, Timeframes for Dental Authorization, Contractor shall notify the Member in writing of the deferral of the decision no later than fourteen (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 twenty-eight (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 7, Utilization Management, Provision C, Timeframes for Dental Authorization, the decision is considered denied and notice of the denial must be sent to the Member on the date the time frame expires.

4. **The Contractor must mail the notice of adverse benefit determination at least 10 days prior to the date of action, when the action is a termination, suspension, or reduction of previously authorized Medi-Cal covered services.**

5. The Contractor must mail the notice of adverse benefit determination by the date of the action when any of the following occur:

    a. The Member has died.
    b. The Member submits a signed written statement requesting service termination.
    c. The Member submits a signed written statement including information that requires service termination or reduction and indicates that he or she understands that service termination or reduction will result.
    d. The Member has been admitted to an institution where he or she is ineligible under the plan for further services.
    e. The Member's address is determined unknown based on returned mail with no forwarding address.
    f. The Member is accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth.
    g. A change in the level or medical care is prescribed by the Member's physician.
    h. The notice involves an adverse determination with regard to preadmission screening requirements of section 1919(e)(7) of the Social Security Act of 1935.
    i. The transfer or discharge from a facility will occur in an expedited fashion.

6. The Contractor may shorten the period of advance notice and mail the notice of adverse benefit determination five days prior to the date of action if:

    a. The Contractor has facts indicating that action should be taken because of probable fraud by the Member; and
    b. The facts have been verified, if possible, through secondary sources.

7. The Contractor must give notice of adverse benefit determination on the date of determination when the action is a denial of payment.

EXHIBIT A, ATTACHMENT 15
MEMBER GRIEVANCE AND APPEAL SYSTEM

A. Member Grievance and Appeal System

Contractor shall ~~implement and maintain~~ **have in place** a Member Grievance **and Appeal** system in accordance with **Title 28 CCR Sections 1300.68 and 1368.01, Title 22 CCR Section 53858, 42 CFR Sections 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.416, and 438.424, and APL 17-003 and any future All Plan Letters related to compliance with the Member Grievance and Appeal System.** ~~(except Subdivision 1300.68(g).), and 1300.68.01, 22 CCR 53858, Exhibit A, Attachment 14, Member Services, Provision D, Written Member Information, Subprovision 4, Paragraph l). Contractor shall resolve each grievance and provide notice to the Member as quickly as the Member's dental condition requires, or no later than thirty (30) calendar days from the date Contractor receives the grievance. Contractor shall notify the Member of the grievance resolution in a written Member notice.~~

1. ~~Member~~ Grievances

A Member may file a Grievance with the Contractor at any time. Contractor shall provide written acknowledgement to the affected Member within five (5) calendar days of receipt of the Grievance. Contractor shall resolve the Grievance and provide notice to the affected Member no later than 30 calendar days from the day Contractor receives the Grievance. Contractor shall notify the affected Member that there is no right to request a State Fair Hearing following Contractor's resolution of the Grievance. Contractor shall accept a Member Grievance either orally or in writing.

2. Standard ~~Member~~ Appeals ~~of an Adverse Benefit Determination~~

a. A Member, or their Provider on behalf of the Member, may request an Appeal of an Adverse Benefit Determination either orally or in writing. The parties to the Appeal included the Member and his or her representative or the legal representative of a deceased Member's estate. The date of an oral Appeal establishes the filing date for the Appeal.

b. A Member can request an Appeal of an Adverse Benefit Determination within 60 calendar days from receipt of the Notice of Adverse Benefit Determination. A Member must have exhausted the Contractor's internal Appeal process prior to proceeding to a State Fair Hearing. Contractor shall have only one level of Appeal for Members.

1) Contractor shall notify a Member who makes an oral request for an Appeal of an Adverse Benefit Determination that the Member's oral request for an Appeal shall be followed by a

written, signed Appeal unless the Member requests an expedited resolution of an Adverse Benefit Determination.

2) Contractor shall assist the Member in preparing a written Appeal including notifying the Member of the location of Contractor's Appeal of an Adverse Benefit Form on Contract's website or providing the form to the Member upon request. Contractor shall also advise and assist the Member in requesting continuation of the disputed benefit(s) during an Appeal of the Adverse Benefit Determination.

c. Contractor shall provide written acknowledgement to the affected Member within five (5) calendar days of receipt of the Appeal. Contractor shall ensure an Appeal of an Adverse Benefit Determination is resolved and provide notice to the affected Member in a format approved by DHCS as expeditiously as the Member's health condition requires, but no later than 30 calendar days from the day Contractor receives the Appeal. In the event Contractor fails to resolve a standard Appeal within 30 calendar days from receipt, it shall provide notice to the Member, upon request, that the Member is deemed to have exhausted Contractor's internal Appeal process and has the right to proceed to a State Fair Hearing.

d. If Contractor or a State Fair Hearing officer reverses an Adverse Benefit Determination and the requested services were not furnished while the Appeal was pending, Contractor must authorize or provide the disputed services as expeditiously as the Member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. If the Member received the disputed service while the Appeal was pending, the Contractor shall pay for those services in accordance with State policy and regulations.

e. If the resolution of the Appeal or State Fair Hearing ~~is adverse to the Member, that is,~~ upholds the Contractor's Adverse Benefit Determination, the Contractor may, consistent with the state's policy on recoveries, under 42 CFR § 431.230(b), and as specified in this contract, recover the cost of services furnished to the Member while the Appeal and State Fair Hearing was pending, to the extent that services were furnished solely because of the requirements of this section.

3. Expedited Appeals ~~of an Adverse Benefit Determination~~

a. For Expedited Appeals of an Adverse Benefit Determination, Contractor shall comply with all requirements in 42 CFR § 438.410.

Contractor shall resolve an Expedited Appeal of an Adverse Benefit Determination and provide notice to the Member in a timeframe that is no longer than 72 hours after Contractor receives the Expedited Appeal unless there are grounds to extend the timeframe under Section 4 of this Provision.

b. If a Contractor denies a request for an expedited resolution of an Appeal, it must transfer the Appeal to the standard timeframe for resolution of no longer than 30 calendar days from the day the Contractor receives the Appeal.

c. If Contractor or a State Fair Hearing officer reverses an Adverse Benefit Determination and the requested services were not furnished while the Appeal was pending, the Contractor must authorize or provide the disputed services as expeditiously as the Member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. If the Member received the disputed service while the Appeal was pending, the Contractor shall pay for those services in accordance with State policy and regulations.

d. Contractor must establish and maintain an expedited review process for appeals, when the Contractor determines (for a request from the Member) or when the provider indicates (in making the request on the Member's behalf or supporting the Member's request) that taking the time for a standard resolution could seriously jeopardize the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

4. Extension of Timeframes

a. Contractor may extend the resolution timeframes for standard and expedited Appeals by up to 14 calendar days if:

1) The Member requests the extension; or

2) Contractor demonstrates to the satisfaction of the Department upon request, that there is a need for additional information and how the delay is in the Member's best interest.

b. In the event that the Contractor extends timeframe without the Member's request ~~is extended~~, Contractor shall:

1) Make reasonable efforts to provide the Member with prompt oral notice of the delay.

2) Provide the Member written notice, within 2 calendar days, of the reason for the decision to extend the timeframe and inform the Member of the right to file a Grievance if he or she disagrees with that decision.

3) Resolve the Appeal as expeditiously as the Member's health requires and in no event ~~can Contractor's resolution~~ extend resolution beyond the initial 14 calendar day extension.

~~d) In the event the Contractor reverses a decision to deny, defer or limit services, the Contractor shall provide the disputed service(s) as expeditiously as possible if a continuation of benefits was not requested.~~

5. Notice of Adverse Benefit Determination

a. A Notice of Adverse Benefit Determination is a formal letter, in a format provided or approved by DHCS, informing a Member of any of the following actions taken by the Contractor:

1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit.

2) The reduction, suspension, or termination of a previously authorized service.

3) The denial, in whole or in part, of payment for a service.

4) The failure to provide services in a timely manner.

5) The failure to act within the required timeframes for standard resolution of Grievances and Appeals.

6) The denial of a Member's request to dispute financial liability.

b. A written Notice of Adverse Benefit Determination shall be in a format and language, that, at a minimum, meets the standards set forth in 42 CFR 438.10 and must include all of the following:

1) The action that the Contractor or its subcontractor has taken or intends to take;

2) The reason for the action, including notification to the Member of the right to request, free of charge, all documents and records, and other relevant information. Such information includes medical necessity criteria, and any process, strategies, or evidentiary standards used in setting coverage limits;

3) The requirement that the Member or Provider request an internal Appeal with Contractor no later than 60 calendar days from the date on the Notice of Adverse Benefit Determination before the Member can request a State Fair Hearing;

4) The Member's right to request a State Fair Hearing and how to request a State Fair Hearing if Contractor fails to send a resolution notice in response to the Appeal of the Notice of Adverse Benefit Determination within 30 calendar days;

5) Procedures for exercising the Member's rights specified in this section;

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 a continuation of benefits.

6. ~~Requirements for~~ Notice of Appeal Resolution ~~of Appeal of an Adverse Benefit Determination~~

Contractor shall provide written notice of the resolution of the Member's Appeal of an Adverse Benefit Determination in a format provided or approved by DHCS. Written notice must include the following:

a. The results of the resolution and the date it was completed.

b. For Appeals not resolved wholly in favor of the Member Contractor's written notice to the Member shall include the following information:

1) The right to request a State Fair Hearing, that a State Fair Hearing must be requested 120 calendar days from Contractors notice of resolution and how to request a State Fair Hearing;

2) The right to request and to receive continuation of benefits while the hearing is pending and how to request continuation of benefits, including the timeframe in which the request shall be made; and

3) The right to request a review of Contractor's resolution by the California Department of Managed Health Care, including but not limited to an Independent Medical Review, if appropriate.

B. Grievance and Appeal System Oversight

Contractor shall implement and maintain procedures as pursuant to 28 CCR 1300.68, 1300.68.01 and **Title** 22 CCR 53858 to monitor Contractor's Member Grievance **and Appeal** system and the expedited review of grievances **and appeals**, which shall include, but **are** not limited to:

1. Procedure to ensure timely **acknowledgement,** resolution and feedback to complainant. ~~Provide verbal notice of the resolution of an expedited review.~~ **In the case of a grievance, Contractor shall provide a written resolution of a grievance within 30 calendar days of receipt. In the case of an Appeal of an Adverse Benefit Determination, Contractor shall provide a written resolution of the Appeal within 30 calendar days of receipt of the Appeal. In the case of an Expedited Appeal, Contractor shall provide oral notification of the resolution of the Expedited Appeal within 72 hours of receipt.**

2. **Procedure to ensure the Member is provided with any reasonable assistance in completing Grievance and Appeal forms and other procedural steps related to a Grievance or Appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers with Teletypewriter Telephone/Telecommunication Devices for the Deaf (TTY/TDD) and interpreter capability.**

3. Procedure for systematic aggregation and analysis of the Grievance **or Appeal** data and use for quality improvement.

4. Procedure to ensure that ~~the~~ **every** Grievance **and Appeal** submitted is reported to an appropriate level, i.e., dental issues versus dental 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 dental care professional with appropriate clinical expertise in treating the Member's condition or disease.

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

6. ~~Procedure to ensure that the person making the final decision for the proposed resolution of a grievance **or appeal** has not participated in any prior decisions related to the grievance **or appeal**.~~ **Procedure to ensure that requirements of Title 22 CCR Section 51014.2 are met regarding services to Members during the Grievance and Appeal process.**

7. Procedure to ensure that the person making the final decision for the proposed resolution of a Grievance **or Appeal** has not participated in any prior decisions related to the Grievance **or Appeal** **and is not a subordinate of any individual who was involved in a previous level of review or decision-making**.

8. **Procedure to ensure that decision makers on Grievances and Appeals of adverse benefit determinations take into account all comments, documents, records, and other information submitted by the Member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.**

9. Procedures to ensure that Members are given a reasonable opportunity ~~to present~~, in **person and in** writing**,** ~~or in person before the individual(s) resolving the grievance **or appeal**~~, to **present** evidence **and testimony and make legal and factual arguments** ~~and law~~ in support of their Grievance **or Appeal**. **In the case of expedited Appeal resolution, Contractor must inform Members of**

the limited time available for this sufficiently in advance of the resolution timeframe.

10. **Procedure to ensure Contractor complies with 42 CFR 438.406(b)(5) and provides the Member and his or her representative the Member's case file, including medical records, other documents and records, and any new additional evidence considered, relied upon, or generated in connection with the Appeal of the adverse benefit determination. The case file must be provided free of charge and sufficiently in advance of the resolution timeframe for standard Appeals (30 calendar days) and expedited Appeals (72 hours)~~resolutions~~.**

11. **Procedure to provide specified information about the Grievance and Appeal system to all providers and subcontractors at the time they enter into a contract.**

C. Grievance and Appeal Log and Quarterly Grievance and Appeal Report

1. Contractor shall maintain, and have available for DHCS review, Grievance **and Appeal** logs, including copies of Grievance **and Appeal** logs of any sub-contracting entity delegated the responsibility to maintain and resolve Grievances **and Appeals**. Grievance **and Appeal** logs shall include all the required information set forth in 22 CCR 53858(e), **Title 28 CCR 1300.68(b)(5), 42 CCR 438.416(b) and (c), and APL 17-003 and any future All Plan Letters.**

2. Contractor shall submit quarterly Grievance **and Appeal** reports in the required DMHC format no later than thirty (30) calendar days following the end of the reporting quarter, to include, but not be limited to, the required elements set forth in 28 CCR 1300.68(f). The Grievance **and Appeal** report should include an explanation for each Grievance **or Appeal** that was not resolved within thirty (30) calendar days of receipt of the Grievance **or Appeal**.

   a. In addition to the types or nature of Grievances **and Appeals** 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 Dentist, issues related to cultural sensitivity and linguistic access, and difficulty with accessing specialists.

   b. In addition to the reporting requirements above, Contractor shall provide the following in the Medi-Cal Category of the report:

      1) The total number of Grievances **and Appeals** received.
      2) The average time it took to resolve Grievances **and Appeals**, which includes providing written notification to the Member.

3) A listing of the zip codes, ethnicity, gender, and primary language of Members who filed Grievances **or Appeals**.

3. Contractor shall submit reports resulting from its quarterly review and analysis of all recorded Grievances **and Appeals** as required by 22 CCR 53858(e)(4) in the required DMHC format. Upon request Contractor shall submit the additional information on a Grievance **or Appeal** to DHCS within five (5) calendar days.

D. Parties to State Hearing

The parties to the State hearing shall include the Contractor as well as the Member and his or her representative or the **legal** representative of a deceased ~~enrollee~~ **Member**'s estate.

E. Recordkeeping Requirements

1. The Contractor and subcontractors shall maintain records of grievances and appeals and must review the information as part of its ongoing monitoring procedures, as well as any updates and revisions to the State quality strategy.

2. The record of each Grievance or Appeal shall contain, at a minimum, all of the following information:

a. A general description of the reason for the Appeal or Grievance.

b. The date the Appeal or Grievance was received.

c. The date of each review or, if applicable, review meeting.

d. Resolution at each level of the Appeal or Grievance, if applicable.

e. Date of resolution at each level, if applicable.

f. Name of the covered person for whom the Appeal or Grievance was filed.

g. The record shall be accurately maintained in a manner accessible to the state and available upon request to CMS.

F. Continuation of Benefits

1. Contractor shall continue the Member's benefits throughout all pending Contractor Appeals and State Fair Hearings if all of the following occur:

   a. The Member files the request for an appeal within 60 calendar days following the date on the adverse benefit determination notice; ~~for an appeal timely~~;

   b. The appeal involves the termination, suspension, or reduction of a previously authorized service;

   c. The Member's services were ordered by an authorized provider;

   d. The period covered by the original authorization has not expired; and

   e. The Member timely files for continuation of benefits. *"Timely files"* means the Member files for continuation of benefits on or before the following, whichever is later:

      1) Within ten (10) calendar days of the Contractor sending the notice of adverse benefit determination.

      2) The intended effective date of the Contractor proposed adverse benefit determination.

2. If, at the Member's request, the Contractor shall continue or reinstate the Member's benefits while the Appeal or State Fair Hearing is pending, the benefits shall continue until one of following occurs:

   a. The Member withdraws the Appeal or request for State Fair Hearing.

   b. The Member fails to request a state fair hearing and continuation of benefits within ten (10) calendar days after the Contractor sends the notice of an adverse resolution to the Member's appeal.

   c. A State Fair Hearing office issues a hearing decision adverse to the Member.

3. If the final resolution of the Appeal or State Fair Hearing is adverse to the Member, that is, upholds Contractor's adverse benefit determination, the Contractor may recover the cost of services furnished to the Member while the Appeal and State Fair Hearing was pending, to the extent that they were furnished solely because of the requirements of this section.

EXHIBIT A, ATTACHMENT 16
ENROLLMENTS AND DISENROLLMENTS

A. 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 Members, and potential enrollees, in making an informed choice in dental plans. Contractor shall submit a copy of the provider directory to DHCS upon request. DHCS reserves the right to halt new enrollment into a plan if the Contractor fails to achieve the benchmarks for the performance measures and/or at the discretion of the Department.

B. Enrollment

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 under beneficiary assignment.

1. 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, need for dental services, or disability.

2. 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.

3. Exception to Enrollment

   An eligible beneficiary in a mandatory aid code category is not required to enroll when a request for an exemption under 22 CCR 53923.5 has been approved.

4. 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.

5. Enrollment Capacity

   All eligible beneficiaries shall be accepted by Contractor up to the limits of Contractor's enrollment capacity approved by DHCS.

6. Reenrollment

   DHCS will automatically reenroll an eligible beneficiary who was disenrolled because he/she lost Medicaid eligibility for a period of 2 months or less.

7. Enrollment Discrimination Prohibited.

The Contractor, PIHPs, PAHPs, PCCMs and PCCM entities shall provide as follows:

a. Accept individuals eligible for enrollment in the order in which they apply without restriction (unless authorized by CMS), up to the limits set under the contract.

b. Enrollment is voluntary, except in the case of mandatory enrollment programs that meet the conditions set forth in 42 § 438.50(a).

c. The Contractor, PIHP, PAHP, PCCM or PCCM entity shall not, on the basis of health status or need for health care services, discriminate against individuals eligible to enroll.

d. The Contractor, PIHP, PAHP, PCCM or PCCM entity shall not discriminate against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability and shall not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin, sex, sexual orientation gender identity, or disability pursuant to 42 CFR § 438.3(d).

C. Continuance of Membership

A Member's enrollment shall continue unless this contract is terminated, or the Member is disenrolled under the conditions described in Provision D, 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 Medi-Cal Dental Managed Care Program, and without a break in service, receives a new contract. Notwithstanding this Provision C, each Member maintains the right to change dental plans at any time.

D. 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:

1. Disenrollment of a Member is mandatory when:

   a. The Member requests disenrollment, subject to any lock-in restrictions on disenrollment under the federal lock-in option, if applicable.

   b. The Member's eligibility for enrollment with Contractor is terminated or eligibility for Medi-Cal is ended, including the death of the Member.

   c. 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.

   d. 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.

   e. There is a change of a Member's place of residence to outside Contractor's service area.

   f. Disenrollment is based on the circumstances described in Exhibit A, Attachment 14, Member Services, Provision 4, Written Member Information, Subprovision 4, Paragraphs t or u.

   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 thirty (30) calendar days prior to that date.

2. Contractor may recommend to DHCS the disenrollment of any Member in the event of a breakdown in the "Contractor/Member relationship" which makes it impossible for Contractor's providers to render services adequately to a Member. Except in cases described in Paragraph b below, or fraud, Contractor shall make, and document, significant efforts to resolve the problem with the Member through avenues such as reassignment of Primary Care Dentist or education before requesting a Contractor-initiated disenrollment. In cases of Contractor-initiated disenrollment of a Member, Contractor must submit to DHCS a written request with

supporting documentation for disenrollment based on the breakdown of the "Contractor/Member relationship." Contractor-initiated disenrollment's must be prior approved by DHCS and shall be considered only under any of the following circumstances:

a. Member is repeatedly verbally abusive to contracting Providers, ancillary or administrative staff, Subcontractor staff or to other plan Members.

b. Member physically assaults a Contractor's staff person, contracting provider or staff person, or other Member, or threatens another individual with a weapon on Contractor's premises or subcontractor's premises. In this instance, Contractor or subcontractor shall file a police or security agency report and file charges against the Member.

c. Member is disruptive to Contractor operations, in general.

d. Member habitually uses providers not affiliated with Contractor for non-emergency services without required authorizations (causing Contractor to be subjected to repeated provider demands for payment for those services or other demonstrable degradation in Contractor's relations with community providers).

e. Member has allowed the fraudulent use of Medi-Cal coverage under the plan, which includes allowing others to use the Member's plan identification card to receive services from Contractor.

f. Contractor may not request disenrollment because of an adverse change in the ~~enrollee~~ **Member's** health status, or because of the ~~enrollee~~ **Member's** utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs in accordance with ~~2~~42 CFR 438.56(b)(2).

3. Members may choose to disenroll from the plan if the plan does not cover the service the Member seeks because of moral or religious objections.

~~3.~~**4.** A Member's failure to follow prescribed treatment (including failure to keep established dental appointments) shall not, in and of itself, be good cause for the approval by DHCS of a Contractor-initiated disenrollment request unless Contractor can demonstrate to DHCS that, as a result of the failure, Contractor is exposed to a substantially greater and unforeseeable risk than that otherwise contemplated under the Contract and rate-setting assumptions.

~~4.~~**5.** The problem resolution attempted prior to a Contractor-initiated disenrollment described in Subprovision 2 above must be documented by Contractor. A formal procedure for Contractor-initiated disenrollments shall be established by Contractor and approved by DHCS. As part of the procedure, the Member shall be notified in

writing by Contractor of the intent to disenroll the Member for cause and allowed a period of no less than twenty (20) calendar days to respond to the proposed action.

a. Contractor must submit a written request for disenrollment and the documentation supporting the request to DHCS for approval. The supporting documentation must establish the pattern of behavior and Contractor's efforts to resolve the problem. DHCS shall review the request and render a decision in writing within ten (10) business days of receipt of a Contractor request and necessary documentation. If the Contractor-initiated request for disenrollment is approved by DHCS, DHCS shall submit the disenrollment request to the Enrollment Contractor for processing. Contractor shall be notified by DHCS of the decision, and if the request is granted, shall be notified by the Enrollment Contractor of the effective date of the disenrollment. Contractor shall notify the Member of the disenrollment for cause if DHCS grants the Contractor-initiated request for disenrollment.

b. Contractor shall continue to provide covered services to the Member until the effective date of the disenrollment.

~~5.~~ **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.

~~6.~~ **7. Regardless of the procedures followed, the effective date of an approved disenrollment must be no later than the first day of the second month following the month in which the Member requests disenrollment or the Contractor refers the request to DHCS. If the Contractor fails to make the determination within the timeframes specified in this section, the disenrollment is considered approved for the effective date that would have been established had DHCS or the Contractor complied within the timeframes specified.**

~~7.~~ **8.** Contractor shall implement and maintain procedures to ensure that all Members requesting disenrollment or information regarding the disenrollment process are immediately referred to the Enrollment Contractor.

E. Record of Member Deaths

Contractor must submit a written report as necessary to DHCS listing deceased members to the extent Contractor has knowledge of a Member's death. The report shall be submitted immediately upon notification and shall include the Member's name, Member's Medi-Cal number, date of birth, and date of death. The absence of reports indicates Contractor does not have knowledge of any Member deaths.

EXHIBIT A, ATTACHMENT 17
MARKETING

A. 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 17, and ensure that all staff performing marketing activities or distributing marketing material is appropriately certified.

1. 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, or practices that reasonably may be interpreted as intended to influence an eligible beneficiary to not enroll in, or disenroll from another plan.

2. 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:

   a. An explanation of the Medi-Cal Dental Program, including both Medi-Cal Dental FFS and capitated Contractors, and eligibility**, and the Beneficiary Support System**.

   b. Medi-Cal Dental Scope of Services.

   c. An explanation of the Contractor's administrative operations and dental health delivery system program, including the service area covered, excluded services, additional services, conditions of enrollment and aid categories.

   d. An explanation of Utilization Management (how the beneficiary is obligated to obtain all non-emergency dental care through the Contractor's provider network and describing all precedents to receipt of care like referrals, prior authorizations, etc.).

   e. An explanation of the Contractor's grievance procedures.

   f. An explanation of how a Member disenrolls from the Contractor and conditions for both voluntary and mandatory disenrollment reasons.

g. An explanation of the requirements of confidentiality of any information obtained from Members including information regarding eligibility under any public welfare or social services program.

h. An explanation of how marketing representatives will be supervised and monitored to assure compliance with regulations.

i. An explanation of acceptable communication and sales techniques. This shall include an explanation of prohibited marketing representative activities and conduct.

j. 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.

k. An explanation that discrimination in enrollment and failure to enroll a Member due to a pre-existing dental condition are illegal.

B. DHCS Approval

1. 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 thirty (30) calendar days prior to the marketing event, unless DHCS agrees to a shorter period. The absence of any written notifications indicates the Contractor does not have any additional marketing activities the Contractor wishes to conduct.

2. Contractor shall notify DHCS at least thirty (30) calendar days in advance of Contractor's participation in all marketing events. In cases where Contractor learns of an event less than thirty (30) calendar days in advance, Contractor shall provide notification to DHCS immediately. Notifications received less than forty-eight (48) hours prior to the event will not be approved by DHCS.

3. 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.

4. Contractor's training and certification program and changes in the training and certification program shall be approved in writing by DHCS prior to implementation.

C. 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 Dental Managed Care Program only. Contractor shall ensure that the marketing plan, all procedures and materials, are accurate and do not mislead, confuse or defraud. **The contractor must distribute marketing materials to its entire service area under 42 CFR § 438.104(b)(1)(ii).**

1. Contractor shall submit a marketing plan to DHCS for review and approval on an annual basis no later than thirty (30) calendar days after the beginning of each calendar year. 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.

    a. The marketing plan shall have a table of contents section that divides the 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.

    b. Contractor's marketing plan shall contain the following items and exhibits:

        1) Mission Statement or Statement of Purpose for the marketing plan.

        2) 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.

        3) 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.

        4) 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:

a) Contractor shall not engage in door to door, cold call, telephone, or other marketing for the purpose of enrolling Members or potential enrollees.

b) 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.

c) Contractor shall not conduct marketing presentations at primary dental care sites.

d) 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.

5) 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 local, 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.

6) Marketing Distribution Methods

A description of the methods the Contractor will use for distributing marketing materials.

7) 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).

8) Miscellaneous

All other information requested by DHCS to assess the Contractor's marketing program.

a) Contractor shall not seek to influence enrollment in conjunction with the sale or offering of any private insurance.

b) The conduct of activities or procedures not included in an approved marketing plan shall constitute a violation of Welfare and Institutions Code Section 14408 and be subject to sanctions in accordance with Section 14409.

EXHIBIT A, ATTACHMENT 18
TARGETED LOW-INCOME CHILD MEMBER TRANSITION

A. Continuity of Care

In addition to Exhibit A, Attachment 11, Access and Availability, Contractor also agrees to the following:

1. Contractor shall provide Targeted Low-Income Child Members who have transitioned to Medi-Cal continued access to their current Primary Care Dentist if the Primary Care Dentist is a contracted provider in the Contractor's Medi-Cal provider network. Contractor shall also provide continued access if the Primary Care Dentist is not within Contractor's Medi-Cal provider network, if the nonparticipating provider agrees in writing to be subject to the same contractual terms and conditions that are imposed upon currently contracting providers providing similar services and who are practicing in the same or a similar geographic area as the nonparticipating provider, including, but not limited to, payment for services, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements. If the nonparticipating provider does not agree to comply or fails to comply with these contractual terms and conditions, the plan is not required to recognize the provider as a plan provider.

2. Contractor shall provide for the completion of covered services for the treatment of certain specified conditions if: (a) the services were being provided by a provider that is within the Contractor's Medi-Cal provider network at the time of the transition, or (b) the covered services were being provided by a nonparticipating provider who agrees to comply with the plan's contractual terms and conditions, as described in A.1. Enrollees are entitled to continuation of services from such providers for the following circumstances and timeframes:

    a) An acute condition (defined as a dental condition that involves a sudden onset of symptoms due to an illness, injury, or other dental problem that requires prompt dental attention and that has a limited duration).

    b) A serious chronic condition. Completion of covered services under this paragraph shall not exceed 12 months from the transition date or 12 months from the effective date of coverage for a newly covered enrollee.

    c) Performance of a surgery or other procedure that is authorized by the Plan as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the transition date or within 180 days of the effective date of coverage for a newly covered enrollee.

3. If a Targeted Low-Income Child Member who has transitioned into Medi-Cal is not able to remain with their Primary Care Dentist, the Contractor shall develop a care plan on how the Member will continue to receive services which they had been receiving at the time of the transition. Contractor shall report this care plan to DHCS

to show how continuity of care is being provided and the outcome of Contractor's care plan, in the manner and format specified by DHCS.

B. Required Reports for the Targeted Low-Income Child Member Transition to Medi-Cal

Contractor shall submit to DHCS the following reports:

1. In addition to the requirements set forth in Exhibit A, Attachment 8, Provider Network, Provision G, Changes to Provider Network Report, the Provider Network report shall include information on whether additions or deletions to the contracted provider list are from providers who had accepted Targeted Low-Income Child Members.

2. In addition to the requirements set forth in Exhibit A, Attachment 15, Provision C, Grievance Log and Quarterly Grievance Report, Contractor shall also include information on grievances related to access to care filed by Targeted Low-Income Child Members who transitioned into Medi-Cal, in the manner and format specified by DHCS.

3. Other information pertaining to transition implementation, enrollees, and providers, as requested by DHCS.

EXHIBIT A, ATTACHMENT 19
DELIVERABLE SCHEDULE

*****The annual reports will be due thirty (30) calendar days after beginning of every calendar year. Quarter 1 will be January-March; Quarter 2 will be April-June; Quarter 3 will be July-September; and Quarter 4 will be October-December.

Deliverable	Provision	Frequency*	Submission Due Date
Key Personnel (Disclosure Form)	Exhibit A, Att. 2, Provision B	Annually	No later than thirty (30) calendar days after the beginning of every calendar year
Annual Certified Financial Statement (audited by a Certified Public Accounted)	Exhibit A, Att. 3, Provision B	Annually	No later than one-hundred and twenty (120) calendar days after the close of Contractor's Fiscal Year
Annual Financial Statements	Exhibit A, Att. 3, Provision B	Annually	No later than one-hundred and twenty (120) calendar days after the close of Contractor's Fiscal Year
Quarterly Financial Statements	Exhibit A, Att. 3, Provision B	Quarterly	No later than forty-five (45) calendar days after the close of Contractor's Fiscal Quarter
Monthly Financial Statements	Exhibit A, Att. 3, Provision C	Monthly, if required by DMHC	No later than thirty (30) calendar days after each reporting month
Medi-Cal Only Financial Statement	Exhibit A, Att. 3, ProvisionB, Subprovision 4 (annual) and Provision B, Subprovision 9 (quarterly)	Annually and Quarterly	No later than one-hundred and twenty (120) calendar days after the close of Contractor's Fiscal Year/no later than forty-five (45) calendar days after the close of Contractor's Fiscal Quarter
Encounter Data	Exhibit A, Att. 4, Provision B	Monthly	Will be notified through an All Plan Letter (APL)
Quality Improvement Committee Meeting Minutes	Exhibit A, Att. 5, Provision D	Quarterly	No later than thirty (30) calendar days after the end of the reporting quarter
Quality Improvement Annual Report	Exhibit A, Att. 5, Provision I	Annually	No later than thirty (30) calendar days after the beginning of every

			calendar year
External Quality Review Compliance Audit	Exhibit A, Att. 5, Provision J	Annually	No later than December 15th of every calendar year
Provider Monitoring Report	Exhibit A, Att. 5, Provision K, Subprovision 4	Quarterly	No later than thirty (30) days after the end of the reporting quarter
Review of Utilization Data	Exhibit A, Att. 7, Provision D	Annually	No later than thirty (30) calendar days after the beginning of every calendar year
Self-Reported Monthly Utilization Data	Exhibit A, Att. 7, Provision D	Monthly	No later than thirty (30) calendar days after the end of the reporting month
Changes to Provider Network Report	Exhibit A, Att. 8, Provision G	Monthly	Within fifteen (15) calendar days following the end of the month
Plan Provider Network Report	Exhibit A, Att. 8, Provision H	Monthly	No later than fifteen (15) calendar days following the end of the reporting month
Timely Access Report	Exhibit A, Att. 11, Provision B, Subprovision 3	Quarterly	No later than thirty (30) calendar days after the end of the reporting quarter
Specialty Referral Report	Exhibit A, Att. 11, Provision B, Subprovision 5	Biannually	No later than January 31st and July 31st of every calendar year
Health Education Programs	Exhibit A, Att. 12, Provision D, Subprovision 1	Annually	No later than thirty (30) calendar days after the beginning of every calendar year
Member Phone Call Report	Exhibit A, Att. 14, Provision B	Monthly	No later than thirty (30) calendar days after the end of the reporting month
Call Center Reports	Exhibit A, Att. 14, Provision C	Biannually	No later than January 31st and July 31st of every calendar year
Member Services Guide (Evidence of Coverage)	Exhibit A, Att. 14, Provision D, Subprovision 4	Annually	No later than thirty (30) calendar days after the beginning of every calendar year
Member Reminder Template	Exhibit A, Att. 14, Provision D, Subprovision 6	Annually	No later than thirty (30) calendar days after the beginning of every

			calendar year
Grievance Report	Exhibit A, Att. 15, Provision C, Subprovision 2	Quarterly	No later than thirty (30) calendar days after the end of the reporting quarter
Marketing Plan	Exhibit A, Att. 17, Provision C. Subprovision 1.	Annually	No later than thirty (30) calendar days after the beginning of every calendar year

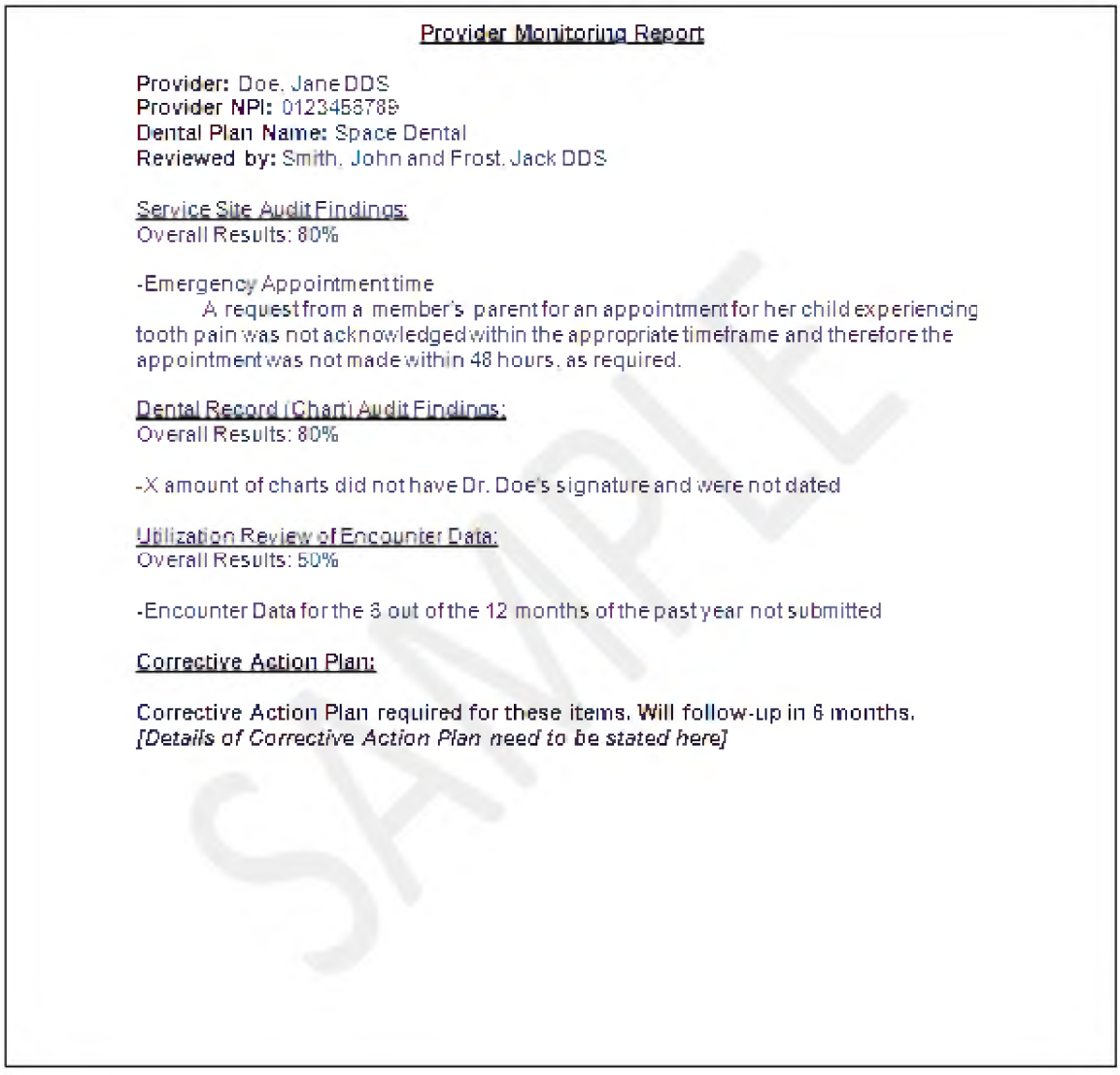
EXHIBIT A, ATTACHMENT 20
DELIVERABLE TEMPLATES

Contractor shall use the templates developed by DHCS in this attachment for submitting specific deliverables. DHCS reserves the right to modify any of the templates or create templates for other deliverables. DHCS will notify Contractor through an All Plan Letter in the event of a change to a template or addition of templates.

1. Medi-Cal Dental Only Financial Statement (Exhibit A, Attachment 3, Provision B, Subprovision 9)

QUARTERLY STATEMENT AS OF [date] - [Plan Name] MEDI-CAL DENTAL ONLY REVENUES & EXPENSES		
Member Months: (X)		
	1	**2**
	Current Period	**Year-To-Date**
REVENUES		
1. MEDI-CAL		
EXPENSES		
2. Dental		
Administration		
3. Compensation		
4. Interest Expense		
5. Occupancy, Depreciation and Amortization		
6. Management Fees		
7. Marketing		
8. Affiliate Ammonization Services		
9. Aggregate Write-Ins for other Administration		
10. Quality Improvement Activities		
11. Program Integrity Activities		
12. TOTAL ADMINISTRATION (Items 3-12)		
14. TOTAL EXPENSES		
15. INCOME (LOSS)		
16. Extraordinary Income (Loss)		
17. Provision for Taxes		
18. Licensing Fees		
19. Regulatory Fees		
20. Remittances Owed to the State (if applicable)		
21. NET INCOME (LOSS)		
22. LOSS RATIO (Item 15/Item 21)		
23. Credibility Adjustment (if applicable)		
24. Adjusted LOSS RATIO		
Methodology for Allocation of Expenditures:		

2. Provider Monitoring Report (Exhibit A, Attachment 5, Provision K, Subprovision 4)



Provider Monitoring Report

Provider: Doe, Jane DDS
Provider NPI: 0123456789
Dental Plan Name: Space Dental
Reviewed by: Smith, John and Frost, Jack DDS

Service Site Audit Findings:
Overall Results: 80%

-Emergency Appointment time
A request from a member's parent for an appointment for her child experiencing tooth pain was not acknowledged within the appropriate timeframe and therefore the appointment was not made within 48 hours, as required.

Dental Record (Chart) Audit Findings:
Overall Results: 80%

-X amount of charts did not have Dr. Doe's signature and were not dated

Utilization Review of Encounter Data:
Overall Results: 50%

-Encounter Data for the 3 out of the 12 months of the past year not submitted

Corrective Action Plan:

Corrective Action Plan required for these items. Will follow-up in 6 months.
[Details of Corrective Action Plan need to be stated here]

3. Specialty Referrals Report (Exhibit A, Attachment 11, Provision B, Subprovision 5)

SPECIALTY REFERRALS REPORT

Plan Name: Space Dental

Reporting Quarter: Q1 of 2012

Number of Referrals Requested	Number of Benes Referred	Number of Benes seen within 30 days	Number of Benes seen within 60 days	Number of Referrals Expired without Benes being seen
65	50	25	10	20

4. Call Center Report (Exhibit A, Attachment 14, Provision C)

CALL CENTER REPORT

Plan Name: _____
Reporting Quarter: _____

Type of Calls	Questions on Benefits	Provider Information	Access to Services	Grievance	Health Education	Specialty Referrals
Number of Calls						

Average Speed of Answering Calls	
Calls Abandonment Rate	
"P" Factor*	

*"P" Factor: The percentage of connected calls versus non-connected calls and/or busy signals

5. Plan Provider Network Report (Exhibit A, Attachment 8, Provision H)

Space Dental Provider Network										
Last	First	NPI	License #	Office Name	Address	Phone Number	Number of Members Assigned	Accepting New Members (Yes/No)	Date Accepting New Members Last Updated	Provider Since Date
Smith	Richard	1111111111	12345	Big Smiles Group	1234 Main St. Sac CA 95825	(916)555-5555	10	Yes	8/10/2011	1/1/2000
Jackson	Joe	2222222222	67891	Big Smiles Group	1235 Main St. Sac CA 95825	(916)555-5556	x	x	x	1/1/2000
Williams	Tina	3333333333	234567	Big Smiles Group	1236 Main St. Sac CA 95825	(916)555-5557	x	x	x	1/1/2000

6. Changes to Plan Provider Network Report (Exhibit A, Attachment 8, Provision G)

Changes to Space Dental's Provider Network

Addition or Deletion (A/D)	Accept HFP*? (Y/N)	Last Name	First Name	NPI	License #	Office Name	Address	Phone Number	Number of Members Assigned	Accepting New Members (Yes/No)	Date Accepting New Members Last Updated	Provider Since Date	Provider Cancellation Date	Members Moved To
A	N	Smith	Richard	1111111111	12345	Big Smiles Group	1234 Main St. Sac CA 95825	(916)555-555	10	Yes	8/10/2011	1/1/2000		
A	N	Jackson	Joe	2222222222	67891	Big Smiles Group	1235 Main St. Sac CA 95825	(916)555-555	x	x	x	1/1/2000		
A	Y	Williams	Tina	3333333333	234567	Big Smiles Group	1236 Main St. Sac CA 95825	(916)555-555	x	x	x	1/1/2000		

*HFP ; Healthy Families Program

7. Corrective Action Plan (Exhibit A, Attachment 5, Provision N)

CORRECTIVE ACTION PLAN

Plan Name:	Space Dental	**Date:**	
Contract #:	13-XXXXX	**Prepared by:**	John Smith
Contact Name:	John Alien		

Encounter Data:

Issue:

Recommendation:

Key Milestones:

Success Measure:

Please Do Not Write Below This Line

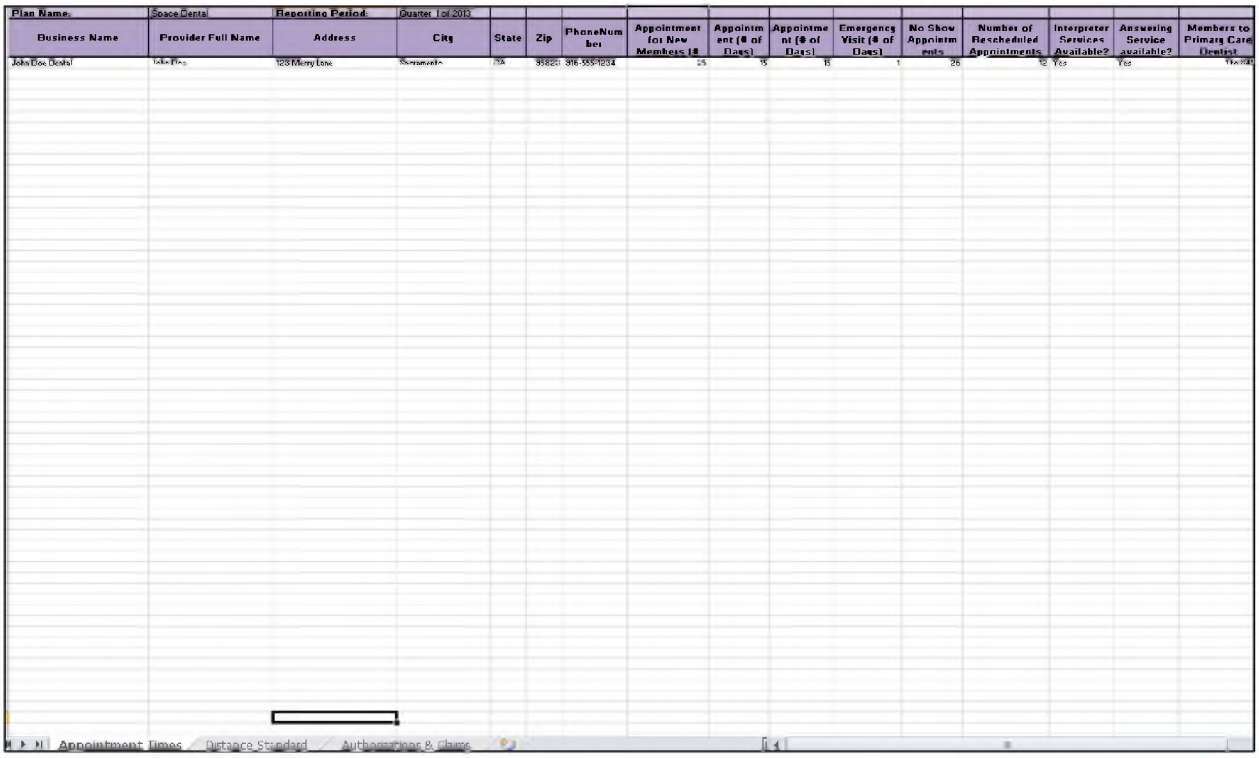
MDSD Approval:
MDSD Denied:
Reviewed By:

Management Approval:

MDSD Comments:

8. Timely Access Report (Exhibit A, Attachment 11, Provision B, Subprovision 3)

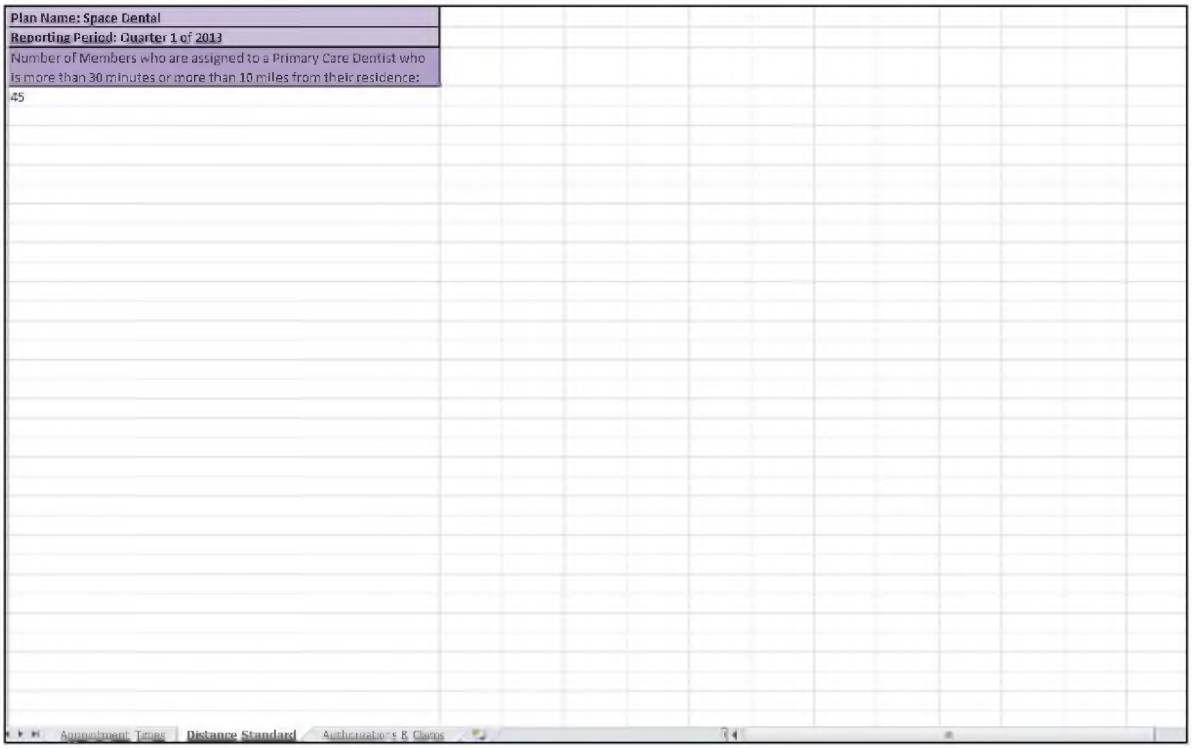
   Appointment Times



Plan Name:	Space Dental	Reporting Period:	Quarter 1 of 2013												
Business Name	Provider Full Name	Address	City	State	Zip	PhoneNumber	Appointment for New Members (#	Appointment (# of Days)	Appointment (# of Days)	Emergency Visit (# of Days)	No Show Appointments	Number of Rescheduled Appointments	Interpreter Services Available?	Answering Service available?	Members to Primary Care Dentist
John Doe Dental	John Doe	123 Merry Lane	Sacramento	CA	95822	916-555-1234	15	15	15	1	26	12	Yes	Yes	Yes

Appointment Times | Distance Standard | Authorizations & Claims

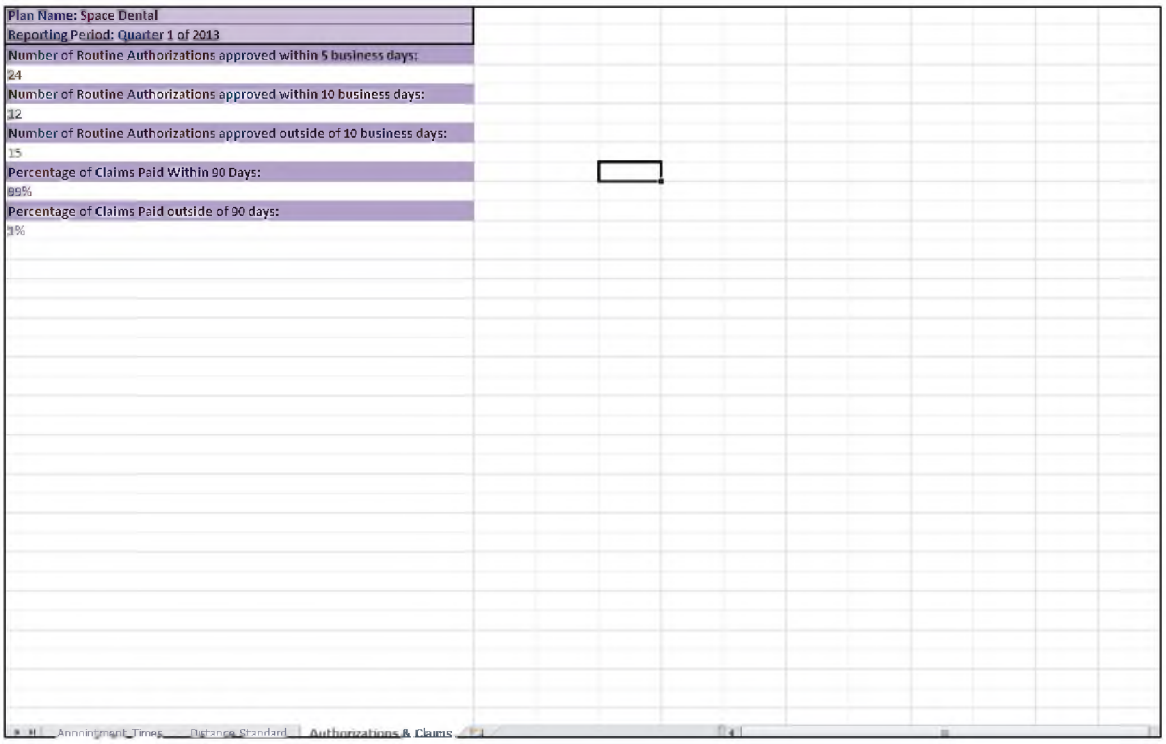
Distance Standard



Plan Name: Space Dental
Reporting Period: Quarter 1 of 2013
Number of Members who are assigned to a Primary Care Dentist who is more than 30 minutes or more than 10 miles from their residence:
45

Appointment Times | Distance Standard | Authorizations & Claims

Authorizations & Claims



Plan Name: Space Dental
Reporting Period: Quarter 1 of 2013
Number of Routine Authorizations approved within 5 business days:
24
Number of Routine Authorizations approved within 10 business days:
12
Number of Routine Authorizations approved outside of 10 business days:
15
Percentage of Claims Paid Within 90 Days:
99%
Percentage of Claims Paid outside of 90 days:
1%

Exhibit B
Budget Detail and Payment Provisions

Clause Index

Index of numbered clauses in **Exhibit B**

Exhibit B
Budget Detail and Payment Provisions

A. Budget Contingency Clause

1. It is mutually agreed that if the Budget Act of the current year and/or any subsequent years covered under this Agreement does not appropriate sufficient funds for the program, this Agreement shall be of no further force and effect. In this event, DHCS shall have no liability to pay any funds whatsoever to Contractor or to furnish any other considerations under this Agreement and Contractor shall not be obligated to perform any provisions of this Agreement.

2. If funding for any fiscal year is reduced or deleted by the Budget Act for purposes of this program, DHCS shall have the option to either cancel this Agreement with no liability occurring to DHCS, or offer an agreement amendment to Contractor to reflect the reduced amount.

B. 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.

C. Capitation Payment

1. Capitation Payment

   DHCS shall remit to Contractor a monthly capitation payment for each Medi-Cal Member that appears on the approved list of Members supplied to Contractor by DHCS. The payment period for health care services shall commence on the first day of the Operations Period. Capitation payments in the amount of $8.42 for adults and $11.45 for children shall be paid at the end of the month for the month of service, subject to provisions E and F of this Exhibit. **Payments are only to be made by the State and retained by the Contractor for Medi-Cal eligible Members.**

2. Derivative Aid Code Updates

   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 in writing to Contractor as soon as practicable after such aid code splits occur.

3. Payment Withhold

   DHCS will withhold thirteen (13) percent of the monthly capitation payment commencing with the first month payment of the Operations Period and continuing until the end of the Operations Period. The withheld funds will be allocated to the following payment categories and reserved for future payment to the Contractor upon successful completion of their annual performance evaluation:

   a. Performance Measures: 10 percent

b. Deliverables: 3 percent

4. Payment of Withheld Funds

   a. Payment of the ten (10) percent monthly withheld funds shall be payable upon the completion of the annual performance evaluation and is subject to Contractor's ability to meet or exceed established benchmarks for specific performance measures during the measurement year. DHCS will evaluate the Contractor's performance on an annual basis which shall commence six (6) months following the end of the measurement year in order to take into account all encounter data submissions for the prior six (6) months. Points will be awarded at the end of the performance evaluation period. The percentage of the retained amount payable to the Contractor will be determined by the points table. (See Exhibit A, Attachment 6, Performance Measures and Benchmarks) Upon completion of the performance evaluation, DHCS will notify plans in writing within ten (10) business days of the evaluation results.

   b. Three (3) percent payment of withheld funds shall be payable at the end of the measurement year and is subject to the Contractor's ability to submit deliverables timely and accurately. Deliverables must be submitted according to Exhibit A, Attachment 19, Deliverable Schedule. At the end of the measurement year, DHCS will determine the amount of the three (3) percent withhold as appropriate, and notify plans in writing of the release within ten (10) business days.

5. Determination of Performance

   a. Performance Measures

      Payment of the ten (10) percent monthly withhold of the Contractor's capitation shall be contingent upon meeting or exceeding the annual established benchmarks for specific performance measures. Each performance measure will be allocated a benchmark threshold. Each threshold will be assigned points. Contractor must meet or exceed the benchmark threshold to be awarded the maximum points. (See Exhibit A, Attachment 6, Performance Measures and Benchmarks)

      1) The Contractor's performance will be evaluated on an annual basis which shall commence six (6) months following the end of the measurement year.

      For each succeeding contract year, the performance measurement year will commence on January 1st and continue for twelve (12) months.

   b. Deliverables

      Payment of the three (3) percent monthly withhold of the Contractor's capitation shall be contingent upon submitting timely and accurate deliverables based upon Exhibit A, Attachment 19, Deliverable Schedule.

      Each deliverable submitted to DHCS will be reviewed for timeliness and accuracy of the information per contract provisions.

6. Bonus Payment

Contractor will have the ability to earn a portion of the five (5) percent bonus above the capitation payment for exceptional performance in concentrated age categories. The bonus will be based on the Contractor's performance measures meeting the bonus benchmark threshold for those age groups. (See Exhibit A, Attachment 6, Performance Measures and Benchmarks)

DHCS will identify the Contractors who have met the bonus benchmarks six (6) months following the end of the measurement year. DHCS will notify plans that qualified for the five (5) percent bonus payment in writing within ten (10) business days.

At no time will the capitation payment (including the withhold payment) combined with the bonus payment, exceed 105% of the capitation payment to the Contractor~~s~~.

a. **Incentive arrangements are for a fixed period of time and performance is measured during the rating period under the contract in which the incentive arrangement is applied.**

b. **Incentive arrangements are not renewed automatically.**

c. **Incentive arrangements are made available to both public and private Contractors under the same terms of performance.**

d. **Contractor participation in an incentive arrangement does not require Contractor to enter into or adher to intergovernmental transfer agreements.**

7. Failure to Perform

   a. DHCS will continually monitor Contractor's compliance with contract requirements. In the event Contractor fails to meet specific requirements, Contractor will have the opportunity to correct the performance standard or deliverable.

      1) DHCS will notify Contractor in writing if the Contractor is at risk of not meeting a specific obligation.

      2) Contractor will be required to submit a CAP, pending DHCS' request, for any requirement that is not met or for deliverables that are not received by DHCS.

      3) DHCS will work closely with Contractor to monitor and assist Contractor in meeting all requirements.

   b. If Contractor is not able to meet or exceed contract performance requirements, Provision C, Subprovision 4, Payment of Withheld Funds, will apply.

   c. DHCS shall have sole discretion in approving any standard or deliverable that is deemed in compliance and considered timely.

   d. In the event Contractor is consistently not able to meet the performance measures, DHCS reserves the right to halt all new enrollments and/or terminate the contract.

8. Interest on Withheld Funds

Interest will not be paid to Contractor for funds withheld by DHCS. Any funds withheld by DHCS pursuant to this Provision C that does not meet the standard described in Subprovision 9, Verification Reviews will not be reimbursed to Contractor.

9. Verification Reviews

   Contractor performance in meeting the standards will be subject to verification reviews by DHCS. Should it be determined based on a verification review that Contractor did not actually meet the standard or that Member dental records do not document the services reported, DHCS will recover any payments made to Contractor for meeting the standard. Contractor shall cooperate fully with DHCS in the verification review and furnish all necessary records and information required by DHCS to complete the review.

D. Capitation Rates Constitute Payment In Full

The capitation rate for each rate period, as calculated by DHCS, are prospective rates and constitute payment in full subject to any stop loss reinsurance by the State 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. It does not include payment for the recoupment of current or previous losses incurred by Contractor. DHCS is not responsible for making payments for recoupment of losses.

E. Determination of Rates

1. DHCS shall determine the capitation rates for the initial period of Operations, through the duration of the contract. DHCS shall make an 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 July 1 through June 30. 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.

2. **DHCS shall determine capitation rates in accordance with 42 CFR § 438.4 and 42 CFR § 438.5.**

3. **DHCS shall ensure that the capitation payment minus any portion of the withhold that is not reasonably achievable is actuarially sound as determined by an actuary. The total amount of the withhold, achievable or not, must be reasonable and take into consideration the Contractor's financial operating needs accounting for the size and characteristics of the populations covered under the contract, as well as the Contractor's capital reserves as measured by the risk-based capital level, months of claims reserve, or other appropriate measure of reserves. The data, assumptions, and methodologies used to determine the portion of the withhold that is reasonably achievable must be submitted as part of the documentation required under 42 CFR § 438.7(b)(6).**

4~~2~~. 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 contract amendment to this contract in accordance with Exhibit E, Additional Provisions, Provision 8, Change Requirements, subject to the following provisions:

a. The contract amendment shall be effective as of July 1 of each year covered by this contract or as stipulated by changes in Legislation or Regulation.

b. In the event there is any delay in a determination to increase or decrease capitation rates, so that a contract amendment may not be processed in time to permit payment of new rates commencing July 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 contract amendment providing for the rate change, DHCS shall make retroactive adjustments for those months for which interim payment was made.

c. By accepting payment of new annual rates prior to full approval by all control agencies of the contract amendment 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:

1) Any underpayment by the State shall be paid to Contractor within thirty (30) calendar days after final approval of the new rates.

2) Any overpayment to Contractor shall be recaptured by DHCS withholding the amount due from Contractor's next capitation check. If the amount to be withheld from that capitation check exceeds twenty-five (25) percent of the capitation payment for that month, amounts up to twenty-five (25) percent shall be withheld from successive capitation payments until the overpayment is fully recovered by the DHCS. At least thirty (30) calendar days prior to seeking such recovery, DHCS shall inform Contractor of the overpayment.

3) Contractor shall report to the State within 60 calendar days when the Contractor identified the capitation payments or other payments in excess of amounts specified in the contract.

d. If mutual agreement between DHCS and Contractor cannot be attained on capitation rates for rate years subsequent to January 1, 2013 resulting from a rate change pursuant to this Provision E or Provision F below, Contractor shall retain the right to terminate the contract, in accordance with Exhibit E, Additional Provisions, Provision 3, Termination. Notification of intent to terminate a contract shall be in writing and provided to DHCS at least nine (9) months prior to the effective date of termination, subject to any earlier termination date negotiated in accordance with Exhibit E, Additional Provisions, Provision 3, regarding Termination. DHCS shall pay the capitation rates last offered for that rate period until the contract is terminated.

e. DHCS shall make every effort to notify and consult with Contractor regarding proposed redetermination of rates pursuant to this section or Provision F below, at the earliest possible time prior to implementation of the new rate.

F. 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 (1) percent of cost (as defined in Title 22 CCR Section 53322) to the Contractor. Any adjustments shall be effectuated through a contract amendment to the contract subject to the following provisions:

1. The contract amendment shall be effective as of the first day of the month in which the change in obligations is effective, as determined by DHCS.

2. In the event DHCS is unable to process the contract amendment 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 contract amendment providing for the change in obligations, DHCS shall make adjustments for those months for which interim payment was made.

3. DHCS and Contractor may negotiate an earlier termination date, pursuant to Exhibit E, Additional Provisions, Provision 3, 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 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 (9) months prior to the effective date of termination, subject to any earlier termination date negotiated in accordance with Exhibit E, Additional Provisions, Provision 3, Termination – Contractor. DHCS shall pay the capitation rates last offered for that rate period until the contract is terminated.

G. 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 will not limit the 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 ninety (90) percent of all costs exceeding one hundred fifteen (115) percent of its income during any Contractor fiscal year.

H. 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.

I. 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 ninety (90) calendar days following termination or expiration of 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.

J. Recovery Of Capitation Payments

DHCS shall have the right to recover from Contractor amounts paid to Contractor in the following circumstances as specified:

1. 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. 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 or under other circumstances as approved by DHCS. If Contractor retains the capitation payments, Contractor shall provide or arrange and pay for all Necessary Dental Covered Services for the Member, until the Member is disenrolled on a non-retroactive basis pursuant to Exhibit A, Attachment 16, Provision D, Disenrollment.

2. 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. At least thirty (30) calendar days prior to seeking such recovery, DHCS shall inform Contractor about the improper payment, and the overpayment to Contractor shall be recaptured by DHCS withholding the amount due from Contractor's next capitation check. If the amount to be withheld from that capitation check exceeds twenty-five (25) percent of the capitation payment for that month, amounts up to twenty-five (25) percent shall be withheld from successive capitation payments until the overpayment is fully recovered by DHCS.

3. If DHCS determines that an improper payment was received by Contractor for any reason not referenced in Subprovision 1 or 2, 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. At least thirty (30) calendar days prior to seeking such recovery, DHCS shall inform Contractor about the improper payment, and the overpayment to Contractor shall be recaptured by DHCS withholding the amount due from Contractor's next capitation check. If the amount to be

withheld from that capitation check exceeds twenty-five (25) percent of the capitation payment for that month, amounts up to twenty-five (25) percent shall be withheld from successive capitation payments until the overpayment is fully recovered by DHCS.

K. Health Insurance Provider Fee

1. Annually, DHCS shall request the Contractor (not exempt from HIPF) to provide DHCS the following information:

   a. Confirmation that the Contractor is subject to the Health Insurance Providers Fee (HIPF).

   b. A copy of the Contractor's submitted Internal Revenue Service (IRS) Form 8963.

   c. A copy of the Contractor's preliminary fee notice from the IRS.

2. The HIPF dollars paid by the plans in the current year vary as a percentage of the Contractor's previous Calendar Year (CY) premiums, so Medi-Cal premiums for the previous calendar year coverage are utilized to calculate the premium adjustment for the HIPF and related taxes.

3. DHCS will include the HIPF adjustments in the calendar fee year as per member per month (PMPM) adjustments to the dental premium for non-affordable care act (ACA) expansion population only. The ACA expansion did not take effect until January 1, 2014; therefore, ACA expansion population is not subject to the 2014 HIPF adjustments.

4. The HIPF add-ons are grossed up for all applicable corporate taxes. Based on research of California (CA) tax law, the Franchise Tax Board (FTB) has determined that the HIPF is deductible for state income tax purposes. The HIPF calculation takes this deduction into account.

5. HIPF rates and add-ons for non-ACA expansion population will be provided to the Contractor as a rate package for the following rate periods:

   a. 13/14 rates 1/2014 - 4/2014: with Assembly Bill (AB) 97 before adult benefit restoration

   b. 13/14 rates 5/2014 - 6/2014: with AB97 and adult benefit restoration

   c. 14/15 rates 7/2014 - 12/2014: with AB97 and adult benefit restoration

   d. 14/15 rates 1/2015 – 6/2015: with AB97 and adult benefit restoration

Rate Term	Dates	Rates Package Title	HIPF Year	HIPF Rate
13/14	1/2014-4/2014	Assembly Bill (AB) 97 before adult benefit restoration	2014	0.04
13/14	5/2014-6/2014	AB97 and adult benefit restoration	2014	0.04
14/15	7/2014-12/2014	AB97 and adult benefit restoration	2014	0.04
14/15	1/2015- 6/2015	AB97 and adult benefit restoration	2015	0.26

6. The 2014 HIPF add-on for non-ACA expansion population is $0.04 for July 1, 2014 through December 31, 2014.

7. The 2015 HIPF add on for non – ACA expansion is $0.26 for January 1, 2015 through June 30, 2015.

Exhibit C
General Terms and Conditions

This page is a place holder for Exhibit C.

The State's General Terms and Conditions (GTC 610) can only be viewed or downloaded from the following Internet site: http://www.ols.dgs.ca.gov/Standard Language/default.htm.

The State's General Terms and Conditions are modified from time to time by the California Department of General Services to comply with changes to federal or state law and the version that applies to the resulting agreement is determined based on the contract start date. DHCS reserves the right to place into the resulting agreement a more current GTC version, when applicable.

If a bidding firm does not have Internet access they are to contact the program identified in the bid cover letter to request a hard or paper copy of the State's General Term and Conditions.

Special Terms and Conditions

(For federally funded service contracts or agreements and grant agreements)

The use of headings or titles throughout this exhibit is for convenience only and shall not be used to interpret or to govern the meaning of any specific term or condition.

The terms "contract", "Contractor" and "Subcontractor" shall also mean, “agreement”, "grant", “grant agreement”, "Grantee" and "Subgrantee" respectively.

The terms “California Department of Health Care Services”, “California Department of Health Services”, „Department of Health Care Services”, “Department of Health Services”, “CDHCS”, “DHCS”, “CDHS”, and “DHS” shall all have the same meaning and refer to the California State agency that is a party to this Agreement.

This exhibit contains provisions that require strict adherence to various contracting laws and policies. Some provisions herein are conditional and only apply if specified conditions exist (i.e., agreement total exceeds a certain amount; agreement is federally funded, etc.). The provisions herein apply to this Agreement unless the provisions are removed by reference on the face of this Agreement, the provisions are superseded by an alternate provision appearing elsewhere in this Agreement, or the applicable conditions do not exist.

Index of Special Terms and Conditions

1. Federal Equal Opportunity Requirements

(Applicable to all federally funded agreements entered into by the Department of Health Care Services)

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 U.S.C. 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 U.S.C. 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 part 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 part 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 Agreement 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 part 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 part 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 U.S.C. 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. Travel and Per Diem Reimbursement

(Applicable if travel and/or per diem expenses are reimbursed with agreement funds.)

Reimbursement for travel and per diem expenses from DHCS under this Agreement shall, unless otherwise specified in this Agreement, be at the rates currently in effect, as established by the California Department of Personnel Administration (DPA), for nonrepresented state employees as stipulated in DHCS" Travel Reimbursement Information Exhibit. If the DPA rates change during the term of the Agreement, the new rates shall apply upon their effective date and no amendment to this Agreement shall be necessary. Exceptions to DPA rates may be approved by DHCS upon the submission of a statement by the Contractor indicating that such rates are not available to the Contractor. No travel outside the State of California shall be reimbursed without prior authorization from DHCS. Verbal authorization should be confirmed in writing. Written authorization may be in a form including fax or email confirmation.

3. Procurement Rules

(Applicable to agreements in which equipment/property, commodities and/or supplies are furnished by DHCS or expenses for said items are reimbursed by DHCS with state or federal funds provided under the Agreement.)

a. Equipment/Property definitions

Wherever the term equipment and/or property is used, the following definitions shall apply:

(1) **Major equipment/property**: A tangible or intangible item having a base unit cost of **$5,000 or more** with a life expectancy of one (1) year or more and is either furnished by DHCS or the cost is reimbursed through this Agreement. Software and videos are examples of intangible items that meet this definition.

(2) **Minor equipment/property**: A tangible item having a base unit cost of **less than $5,000** with a life expectancy of one (1) year or more and is either furnished by DHCS or the cost is reimbursed through this Agreement.

b. **Government and public entities** (including state colleges/universities and auxiliary organizations), whether acting as a contractor and/or subcontractor, may secure all commodities, supplies, equipment and services related to such purchases that are required in performance of this Agreement. Said procurements are subject to Paragraphs d through h of Provision 3. Paragraph c of Provision 3 shall also apply, if equipment/property purchases are delegated to subcontractors that are nonprofit organizations or commercial businesses.

c. **Nonprofit organizations and commercial businesses**, whether acting as a contractor and/or subcontractor, may secure commodities, supplies, equipment/property and services related to such purchases for performance under this Agreement.

(1) Equipment/property purchases shall not exceed $50,000 annually.

To secure equipment/property above the annual maximum limit of $50,000, the Contractor shall

make arrangements through the appropriate DHCS Program Contract Manager, to have all remaining equipment/property purchased through DHCS" Purchasing Unit. The cost of equipment/property purchased by or through DHCS shall be deducted from the funds available in this Agreement. Contractor shall submit to the DHCS Program Contract Manager a list of equipment/property specifications for those items that the State must procure. DHCS may pay the vendor directly for such arranged equipment/property purchases and title to the equipment/property will remain with DHCS. The equipment/property will be delivered to the Contractor's address, as stated on the face of the Agreement, unless the Contractor notifies the DHCS Program Contract Manager, in writing, of an alternate delivery address.

(2) All equipment/property purchases are subject to Paragraphs d through h of Provision 3. Paragraph b of Provision 3 shall also apply, if equipment/property purchases are delegated to subcontractors that are either a government or public entity.

(3) Nonprofit organizations and commercial businesses shall use a procurement system that meets the following standards:

(a) Maintain a code or standard of conduct that shall govern the performance of its officers, employees, or agents engaged in awarding procurement contracts. No employee, officer, or agent shall participate in the selection, award, or administration of a procurement, or bid contract in which, to his or her knowledge, he or she has a financial interest.

(b) Procurements shall be conducted in a manner that provides, to the maximum extent practical, open, and free competition.

(c) Procurements shall be conducted in a manner that provides for all of the following:

[1] Avoid purchasing unnecessary or duplicate items.

[2] Equipment/property solicitations shall be based upon a clear and accurate description of the technical requirements of the goods to be procured.

[3] Take positive steps to utilize small and veteran owned businesses.

d. Unless waived or otherwise stipulated in writing by DHCS, prior written authorization from the appropriate DHCS Program Contract Manager will be required before the Contractor will be reimbursed for any purchase of $5,000 or more for commodities, supplies, equipment/property, and services related to such purchases. The Contractor must provide in its request for authorization all particulars necessary, as specified by DHCS, for evaluating the necessity or desirability of incurring such costs. The term "purchase" excludes the purchase of services from a subcontractor and public utility services at rates established for uniform applicability to the general public.

e. In special circumstances, determined by DHCS (e.g., when DHCS has a need to monitor certain purchases, etc.), DHCS may require prior written authorization and/or the submission of paid vendor receipts for any purchase, regardless of dollar amount. DHCS reserves the right to either deny claims for reimbursement or to request repayment for any Contractor and/or subcontractor purchase that DHCS determines to be unnecessary in carrying out performance under this Agreement.

f. The Contractor and/or subcontractor must maintain a copy or narrative description of the procurement system, guidelines, rules, or regulations that will be used to make purchases under this Agreement. The State reserves the right to request a copy of these documents and to inspect the purchasing practices of the Contractor and/or subcontractor at any time.

g. For all purchases, the Contractor and/or subcontractor must maintain copies of all paid vendor invoices, documents, bids and other information used in vendor selection, for inspection or audit. Justifications supporting the absence of bidding (i.e., sole source purchases) shall also be maintained on file by the Contractor and/or subcontractor for inspection or audit.

h. DHCS may, with cause (e.g., with reasonable suspicion of unnecessary purchases or use of inappropriate purchase practices, etc.), withhold, cancel, modify, or retract the delegated purchase authority granted under Paragraphs b and/or c of Provision 3 by giving the Contractor no less than 30 calendar days written notice.

4. Equipment/Property Ownership / Inventory / Disposition

(Applicable to agreements in which equipment/property is furnished by DHCS and/or when said items are purchased or reimbursed by DHCS with state or federal funds provided under the Agreement.)

a. Wherever the term equipment and/or property is used in Provision 4, the definitions in Paragraph a of Provision 3 shall apply.

Unless otherwise stipulated in this Agreement, all equipment and/or property that is purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement shall be considered state equipment and the property of DHCS.

(1) **Reporting of Equipment/Property Receipt -** DHCS requires the reporting, tagging and annual inventorying of all equipment and/or property that is furnished by DHCS or purchased/reimbursed with funds provided through this Agreement.

Upon receipt of equipment and/or property, the Contractor shall report the receipt to the DHCS Program Contract Manager. To report the receipt of said items and to receive property tags, Contractor shall use a form or format designated by DHCS" Asset Management Unit. If the appropriate form (i.e., Contractor Equipment Purchased with DHCS Funds) does not accompany this Agreement, Contractor shall request a copy from the DHCS Program Contract Manager.

(2) **Annual Equipment/Property Inventory -** If the Contractor enters into an agreement with a term of more than twelve months, the Contractor shall submit an annual inventory of state equipment and/or property to the DHCS Program Contract Manager using a form or format designated by DHCS" Asset Management Unit. If an inventory report form (i.e., Inventory/Disposition of DHCS-Funded Equipment) does not accompany this Agreement, Contractor shall request a copy from the DHCS Program Contract Manager. Contractor shall:

(a) Include in the inventory report, equipment and/or property in the Contractor's possession and/or in the possession of a subcontractor (including independent consultants).

(b) Submit the inventory report to DHCS according to the instructions appearing on the inventory form or issued by the DHCS Program Contract Manager.

(c) Contact the DHCS Program Contract Manager to learn how to remove, trade-in, sell, transfer or survey off, from the inventory report, expired equipment and/or property that is no longer wanted, usable or has passed its life expectancy. Instructions will be supplied by either the DHCS Program Contract Manager or DHCS" Asset Management Unit.

b. Title to state equipment and/or property shall not be affected by its incorporation or attachment to any property not owned by the State.

c. Unless otherwise stipulated, DHCS shall be under no obligation to pay the cost of restoration, or rehabilitation of the Contractor's and/or Subcontractor's facility which may be affected by the removal of any state equipment and/or property.

d. The Contractor and/or Subcontractor shall maintain and administer a sound business program for ensuring the proper use, maintenance, repair, protection, insurance and preservation of state equipment and/or property.

(1) In administering this provision, DHCS may require the Contractor and/or Subcontractor to repair or replace, to DHCS" satisfaction, any damaged, lost or stolen state equipment and/or property. In the event of state equipment and/or miscellaneous property theft, Contractor and/or Subcontractor shall immediately file a theft report with the appropriate police agency or the California Highway Patrol and Contractor shall promptly submit one copy of the theft report to the DHCS Program Contract Manager.

e. Unless otherwise stipulated by the Program funding this Agreement, equipment and/or property purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, shall only be used for performance of this Agreement or another DHCS agreement.

f. Within sixty (60) calendar days prior to the termination or end of this Agreement, the Contractor shall provide a final inventory report of equipment and/or property to the DHCS Program Contract Manager and shall, at that time, query DHCS as to the requirements, including the manner and method, of returning state equipment and/or property to DHCS. Final disposition of equipment and/or property shall be at DHCS expense and according to DHCS instructions. Equipment and/or property disposition instructions shall be issued by DHCS immediately after receipt of the final inventory report. At the termination or conclusion of this Agreement, DHCS may at its discretion, authorize the continued use of state equipment and/or property for performance of work under a different DHCS agreement.

g. Motor Vehicles

(Applicable only if motor vehicles are purchased/reimbursed with agreement funds or furnished by DHCS under this Agreement.)

(1) If motor vehicles are purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, within thirty (30) calendar days prior to the termination or end of this Agreement, the Contractor and/or Subcontractor shall return such vehicles to DHCS and shall deliver all necessary documents of title or registration to enable the proper transfer of a marketable title to DHCS.

(2) If motor vehicles are purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, the State of California shall be the legal owner of said motor vehicles and the Contractor shall be the registered owner. The Contractor and/or a subcontractor may only use said vehicles for performance and under the terms of this Agreement.

(3) The Contractor and/or Subcontractor agree that all operators of motor vehicles, purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, shall hold a valid State of California driver's license. In the event that ten or more passengers are to be transported in any one vehicle, the operator shall also hold a State of California Class B driver's license.

(4) If any motor vehicle is purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, the Contractor and/or Subcontractor, as applicable, shall provide, maintain, and certify that, at a minimum, the following type and amount of automobile liability insurance is in effect during the term of this Agreement or any extension period during which any vehicle remains in the Contractor's and/or Subcontractor's possession:

Automobile Liability Insurance

(a) The Contractor, by signing this Agreement, hereby certifies that it possesses or will obtain automobile liability insurance in the amount of $1,000,000 per occurrence for bodily injury and property damage combined. Said insurance must be obtained and made effective upon the delivery date of any motor vehicle, purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, to the Contractor and/or Subcontractor.

(b) The Contractor and/or Subcontractor shall, as soon as practical, furnish a copy of the certificate of insurance to the DHCS Program Contract Manager. The certificate of insurance shall identify the DHCS contract or agreement number for which the insurance applies.

(c) The Contractor and/or Subcontractor agree that bodily injury and property damage liability insurance, as required herein, shall remain in effect at all times during the term of this Agreement or until such time as the motor vehicle is returned to DHCS.

(d) The Contractor and/or Subcontractor agree to provide, at least thirty (30) days prior to the expiration date of said insurance coverage, a copy of a new certificate of insurance evidencing continued coverage, as indicated herein, for not less than the remainder of the term of this Agreement, the term of any extension or continuation thereof, or for a period of not less than one (1) year.

(e) The Contractor and/or Subcontractor, if not a self-insured government and/or public entity, must provide evidence, that any required certificates of insurance contain the following provisions:

[1] The insurer will not cancel the insured's coverage without giving thirty (30) calendar days prior written notice to the State (California Department of Health Care Services).

[2] The State of California, its officers, agents, employees, and servants are included as additional insureds, but only with respect to work performed for the State under this Agreement and anyextension or continuation of this Agreement.

[3] The insurance carrier shall notify the California Department of Health Care Services (DHCS), in writing, of the Contractor's failure to pay premiums; its cancellation of such policies; or any other substantial change, including, but not limited to, the status, coverage, or scope of the required insurance. Such notices shall contain a reference to each agreement number for which the insurance was obtained.

(f) The Contractor and/or Subcontractor is hereby advised that copies of certificates of insurance may be subject to review and approval by the Department of General Services (DGS), Office of Risk and Insurance Management. The Contractor shall be notified by DHCS, in writing, if this provision is applicable to this Agreement. If DGS approval of the certificate of insurance is required, the Contractor agrees that no work or services shall be performed prior to obtaining said approval.

(g) In the event the Contractor and/or Subcontractor fails to keep insurance coverage, as required herein, in effect at all times during vehicle possession, DHCS may, in addition to any other remedies it may have, terminate this Agreement upon the occurrence of such event.

5. Subcontract Requirements

(Applicable to agreements under which services are to be performed by subcontractors including independent consultants.)

a. Prior written authorization will be required before the Contractor enters into or is reimbursed for any subcontract for services costing $5,000 or more. Except as indicated in Paragraph a(3) herein, when securing subcontracts for services exceeding $5,000, the Contractor shall obtain at least three bids or justify a sole source award.

(1) The Contractor must provide in its request for authorization, all information necessary for evaluating the necessity or desirabilityof incurring such cost.

(2) DHCS may identify the information needed to fulfill this requirement.

(3) Subcontracts performed by the following entities or for the service types listed below are exempt from the bidding and sole source justification requirements:

(a) A local governmental entity or the federalgovernment,
(b) A State college or State university from any State,
(c) A Joint Powers Authority,
(d) An auxiliary organization of a California State University or a California community college,
(e) A foundation organized to support the Board of Governors of the California Community Colleges,
(f) An auxiliary organization of the Student Aid Commission established under Education Code § 69522,
(g) Firms or individuals proposed for use and approved by DHCS" funding Program via acceptance of an application or proposal for funding or pre/post contract award negotiations,
(h) Entities and/or service types identified as exempt from advertising and competitive bidding in State Contracting Manual Chapter 5 Section 5.80 Subsection B.3. View this publication at the following Internet address: http://www.dgs.ca.gov/ols/Resources/StateContractManual.aspx.

b. DHCS reserves the right to approve or disapprove the selection of subcontractors and with advance written notice, require the substitution of subcontractors and require the Contractor to terminate subcontracts entered into in support of this Agreement.

(1) Upon receipt of a written notice from DHCS requiring the substitution and/or termination of a subcontract, the Contractor shall take steps to ensure the completion of any work in progress and select a replacement, if applicable, within 30 calendar days, unless a longer period is agreed to by DHCS.

c. Actual subcontracts (i.e., written agreement between the Contractor and a subcontractor) of $5,000 or more are subject to the prior review and written approval of DHCS. DHCS may, at its discretion, elect to waive this right. All such waivers shall be confirmed in writing by DHCS.

d. Contractor shall maintain a copy of each subcontract entered into in support of this Agreement and shall, upon request by DHCS, **CMS, OIG or Comptroller General,** make copies available for approval, inspection, or audit.

e. DHCS assumes no responsibility for the payment of subcontractors used in the performance of this Agreement. Contractor accepts sole responsibility for the payment of subcontractors used in the performance of this Agreement.

f. The Contractor is responsible for all performance requirements under this Agreement even though performance may be carried out through a subcontract.

g. The Contractor shall ensure that all subcontracts for services include provision(s) requiring compliance with applicable terms and conditions specified in this Agreement.

h. The Contractor agrees to include the following clause, relevant to record retention, in all subcontracts for services:

"(*Subcontractor Name*) agrees to maintain and preserve, until three years after termination of (*Agreement Number*) and final payment from DHCS to the Contractor, to permit DHCS or any duly authorized representative, to have access to, examine or audit any pertinent books, documents, papers and records related to this subcontract and to allow interviews of any employees who might reasonably have information related to such records."

i. Unless otherwise stipulated in writing by DHCS, the Contractor shall be the subcontractor's sole point of contact for all matters related to performance and payment under this Agreement.

j. The delegated activities or obligations, and related reporting responsibilities, shall be specified in the contract or written agreement.

k. The subcontractor agrees to perform the delegated activities and reporting responsibilities as specified and in compliance with the Contractor's obligations.

l. The contract or written arrangement requires that if any of the Contractor's activities or obligations under its contract with the State are delegated to the subcontractor, then the contract or written arrangement between the Contractor and the subcontractor shall provide either for the revocation of the delegation of activities or obligations, or specify other remedies in instances where DHCS or the Contractor determine that the subcontractor has not performed satisfactorily.

m. The subcontractor shall agree to comply with all applicable Medicaid laws, regulations, including applicable sub-regulatory guidance and contract provisions.

n. DHCS, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under Contractor's contract with DHCS.

o. The contract between the Contractor and the subcontractor requires that the subcontractor ~~shall~~ make available, for purposes of an audit, evaluation, or inspection by DHCS, CMS, the DHHS Inspector General, the Comptroller General or their designees, ~~of~~ its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Denti-Cal Members.

p. **The right to audit under section (n) shall exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.**

q. ~~q.~~ **The contract between the Contractor and the subcontractor requires that If DHCS, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.**

~~j.~~**r.** Contractor shall, as applicable, advise all subcontractors of their obligations pursuant to the following numbered provisions of this Exhibit: 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, 12, 13, 14, 17, 19, 20, 24, 32 and/or other numbered provisions herein that are deemed applicable.

6. Income Restrictions

Unless otherwise stipulated in this Agreement, the Contractor agrees that any refunds, rebates, credits, or other amounts (including any interest thereon) accruing to or received by the Contractor under this Agreement shall be paid by the Contractor to DHCS, to the extent that they are properly allocable to costs for which the Contractor has been reimbursed by DHCS under this Agreement.

7. Audit and Record Retention

(Applicable to agreements in excess of $10,000.)

a. The Contractor and/or Subcontractor shall maintain books, records, documents, and other evidence, accounting procedures and practices, sufficient to properly reflect all direct and indirect costs of whatever nature claimed to have been incurred in the performance of this Agreement, including any matching costs and expenses. The foregoing constitutes "records" for the purpose of this provision.

b. ~~The Contractor's and/or subcontractor's facility or office or such part thereof as may be engaged in the performance of this Agreement and his/her records shall be subject at all reasonable times to inspection, audit, and reproduction~~ **by DHCS, CMS, OIG or Comptroller General**.

DHCS, CMS, the HHS Inspector General, the Comptroller General, and their designees may, at any time, inspect and audit any records or documents of the Contractor, or its subcontractors, and may, at any time inspect the premises, physical facilities, and equipment that pertain to any aspect of services and activities performed, or determination of amounts payable under Contractor's contract with DHCS. This includes any records pertaining to the ability of the Contractor to bear the risk of financial losses, and the services performed or payable amounts under the contract.

c. Contractor agrees that DHCS, the Department of General Services, the Bureau of State Audits, or their designated representatives including the Comptroller General of the United States shall have the right to review and to copy any records and supporting documentation pertaining to the performance of this Agreement. Contractor agrees to allow the auditor(s) access to such records during normal business hours and to allow interviews of any employees who might reasonably have information related to such records. Further, the Contractor agrees to include a similar right of the State to audit records and interview staff in any subcontract related to performance of this Agreement. (GC 8546.7, CCR Title 2, Section 1896).

d. The Contractor and/or Subcontractor shall preserve and make available his/her records (1) for a period of ~~three~~ **ten (10)** years from the date of final payment under this Agreement, and (2) for such longer period, if any, as is required by applicable statute, by any other provision of this Agreement, or by subparagraphs (1) or (2) below.

(1) If this Agreement is completely or partially terminated, the records relating to the work terminated shall be preserved and made available for a period of ~~three~~ **ten (10)** years from the date of any resulting final settlement.

(2) If any litigation, claim, negotiation, audit, or other action involving the records has been started before the expiration of the ~~three~~ **ten** -year period, the records shall be retained until completion of the action and resolution of all issues which arise from it, or until the end of the regular ~~three~~ **ten** -year period, whichever is later.

e. The Contractor and/or Subcontractor shall comply with the above requirements and be aware of the penalties for violations of fraud and for obstruction of investigation as set forth in Public Contract Code §

10115.10, if applicable.

f. The Contractor and/or Subcontractor may, at its discretion, following receipt of final payment under this Agreement, reduce its accounts, books and records related to this Agreement to microfilm, computer disk, CD ROM, DVD, or other data storage medium. Upon request by an authorized representative to inspect, audit or obtain copies of said records, the Contractor and/or Subcontractor must supply or make available applicable devices, hardware, and/or software necessary to view, copy and/or print said records. Applicable devices may include, but are not limited to, microfilm readers and microfilm printers, etc.

g. The Contractor shall, if applicable, comply with the Single Audit Act and the audit reporting requirements set forth in OMB Circular A-133.

8. 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.

9. Federal Contract Funds

(Applicable only to that portion of an agreement funded in part or whole with federal funds.)

a. It is mutually understood between the parties that this Agreement 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 Agreement were executed after that determination was made.

b. This agreement 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 Agreement. In addition, this Agreement is subject to any additional restrictions, limitations, or conditions enacted by the Congress or any statute enacted by the Congress which may affect the provisions, terms or funding of this Agreement in any manner.

c. It is mutually agreed that if the Congress does not appropriate sufficient funds for the program, this Agreement shall be amended to reflect any reduction in funds.

d. DHCS has the option to invalidate or cancel the Agreement with 30-days advance written notice or to amend the Agreement to reflect any reduction in funds.

10. Intellectual Property Rights

a. Ownership

(1) Except where DHCS has agreed in a signed writing to accept a license, DHCS shall be and remain, without additional compensation, the sole owner of any and all rights, title and interest in all Intellectual Property, from the moment of creation, whether or not jointly conceived, that are made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement.

(2) For the purposes of this Agreement, Intellectual Property means recognized protectable rights and interest such as: patents, (whether or not issued) copyrights, trademarks, service marks, applications for any of the foregoing, inventions, trade secrets, trade dress, logos, insignia, color combinations, slogans, moral rights, right of publicity, author's rights, contract and licensing rights, works, mask works, industrial design rights, rights of priority, know how, design flows, methodologies, devices, business processes, developments, innovations, good will and all other legal rights protecting intangible proprietary information as may exist now and/or here after come into existence, and all renewals and extensions, regardless of whether those rights arise under the laws of the United States, or any other state, country or jurisdiction.

(a) For the purposes of the definition of Intellectual Property, "works" means all literary works, writings and printed matter including the medium by which they are recorded or reproduced, photographs, art work, pictorial and graphic representations and works of a similar nature, film, motion pictures, digital images, animation cells, and other audiovisual works including positives and negatives thereof, sound recordings, tapes, educational materials, interactive videos and any other materials or products created, produced, conceptualized and fixed in a tangible medium of expression. It includes preliminary and final products and any materials and information developed for the purposes of producing those final products. Works does not include articles submitted to peer review or reference journals or independent research projects.

(3) In the performance of this Agreement, Contractor will exercise and utilize certain of its Intellectual Property in existence prior to the effective date of this Agreement. In addition, under this Agreement, Contractor may access and utilize certain of DHCS" Intellectual Property in existence prior to the effective date of this Agreement. Except as otherwise set forth herein, Contractor shall not use any of DHCS" Intellectual Property now existing or hereafter existing for any purposes without the prior written permission of DHCS. Except as otherwise set forth herein, neither the Contractor nor DHCS shall give any ownership interest in or rights to its Intellectual Property to the other Party. If during the term of this Agreement, Contractor accesses any third-party Intellectual Property that is licensed to DHCS, Contractor agrees to abide by all license and confidentiality restrictions applicable to DHCS in the third-party's license agreement.

(4) Contractor agrees to cooperate with DHCS in establishing or maintaining DHCS" exclusive rights in the Intellectual Property, and in assuring DHCS" sole rights against third parties with respect to the Intellectual Property. If the Contractor enters into any agreements or subcontracts with other parties in order to perform this Agreement, Contractor shall require the terms of the Agreement(s) to include all Intellectual Property provisions. Such terms must include, but are not limited to, the subcontractor assigning and agreeing to assign to DHCS all rights, title and interest in Intellectual Property made, conceived, derived from, or reduced to practice by the subcontractor, Contractor or DHCS and which result directly or indirectly from this Agreement or any subcontract.

(5) Contractor further agrees to assist and cooperate with DHCS in all reasonable respects, and execute all documents and, subject to reasonable availability, give testimony and take all further acts reasonably necessary to acquire, transfer, maintain, and enforce DHCS" Intellectual Property rights and interests.

b. Retained Rights / License Rights

(1) Except for Intellectual Property made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement, Contractor shall retain title to all of its Intellectual Property to the extent such Intellectual Property is in existence prior to the effective date of this Agreement. Contractor hereby grants to DHCS, without additional compensation, a permanent, non-exclusive, royalty free, paid-up, worldwide, irrevocable, perpetual, non-terminable license to use, reproduce, manufacture, sell, offer to sell, import, export, modify, publicly and privately display/perform, distribute, and dispose Contractor's Intellectual Property with the right to sublicense through multiple layers, for any purpose whatsoever, to the extent it is incorporated in the Intellectual Property resulting from this Agreement, unless Contractor assigns all rights, title and interest in the Intellectual Property as set forth herein.

(2) Nothing in this provision shall restrict, limit, or otherwise prevent Contractor from using any ideas, concepts, know-how, methodology or techniques related to its performance under this Agreement, provided that Contractor's use does not infringe the patent, copyright, trademark rights, license or other Intellectual Property rights of DHCS or third party, or result in a breach or default of any provisions of this Exhibit or result in a breach of any provisions of law relating to confidentiality.

c. Copyright

(1) Contractor agrees that for purposes of copyright law, all works [as defined in Paragraph a, subparagraph (2)(a) of this provision] of authorship made by or on behalf of Contractor in connection with Contractor's performance of this Agreement shall be deemed "works made for hire". Contractor further agrees that the work of each person utilized by Contractor in connection with the performance of this Agreement will be a "work made for hire," whether that person is an employee of Contractor or that person has entered into an agreement with Contractor to perform the work. Contractor shall enter

into a written agreement with any such person that: (i) all work performed for Contractor shall be deemed a "work made for hire" under the Copyright Act and (ii) that person shall assign all right, title, and interest to DHCS to any work product made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement.

(2) All materials, including, but not limited to, visual works or text, reproduced or distributed pursuant to this Agreement that include Intellectual Property made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement, shall include DHCS" notice of copyright, which shall read in 3mm or larger typeface: "© *[Enter Current Year e.g., 2010, etc.]*, California Department of Health Care Services. This material may not be reproduced or disseminated without prior written permission from the California Department of Health Care Services." This notice should be placed prominently on the materials and set apart from other matter on the page where it appears. Audio productions shall contain a similar audio notice of copyright.

d. Patent Rights

With respect to inventions made by Contractor in the performance of this Agreement, which did not result from research and development specifically included in the Agreement's scope of work, Contractor hereby grants to DHCS a license as described under Section b of this provision for devices or material incorporating, or made through the use of such inventions. If such inventions result from research and development work specifically included within the Agreement's scope of work, then Contractor agrees to assign to DHCS, without additional compensation, all its right, title and interest in and to such inventions and to assist DHCS in securing United States and foreign patents with respect thereto.

e. Third-Party Intellectual Property

Except as provided herein, Contractor agrees that its performance of this Agreement shall not be dependent upon or include any Intellectual Property of Contractor or third party without first: (i) obtaining DHCS" prior written approval; and (ii) granting to or obtaining for DHCS, without additional compensation, a license, as described in Section b of this provision, for any of Contractor's or third-party's Intellectual Property in existence prior to the effective date of this Agreement. If such a license upon the these terms is unattainable, and DHCS determines that the Intellectual Property should be included in or is required for Contractor's performance of this Agreement, Contractor shall obtain a license under terms acceptable to DHCS.

f. Warranties

(1) Contractor represents and warrants that:

(a) It is free to enter into and fully perform this Agreement.

(b) It has secured and will secure all rights and licenses necessary for its performance of this Agreement.

(c) Neither Contractor's performance of this Agreement, nor the exercise by either Party of the rights granted in this Agreement, nor any use, reproduction, manufacture, sale, offer to sell, import, export, modification, public and private display/performance, distribution, and disposition of the Intellectual Property made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement will infringe upon or violate any Intellectual Property right, non-disclosure obligation, or other proprietary right or interest of any third-party or entity now existing under the laws of, or hereafter existing or issued by, any state, the United States, or any foreign country. There is currently no actual or threatened claim by any such third party based on an alleged violation of any such right by Contractor.

(d) Neither Contractor's performance nor any part of its performance will violate the right of privacy of, or constitute a libel or slander against any person or entity.

(e) It has secured and will secure all rights and licenses necessary for Intellectual Property including, but not limited to, consents, waivers or releases from all authors of music or performances used, and talent (radio, television and motion picture talent), owners of any interest in and to real estate, sites, locations, property or props that may be used or shown.

(f) It has not granted and shall not grant to any person or entity any right that would or might derogate, encumber, or interfere with any of the rights granted to DHCS in this Agreement.

(g) It has appropriate systems and controls in place to ensure that state funds will not be used in the performance of this Agreement for the acquisition, operation or maintenance of computer software in violation of copyright laws.

(h) It has no knowledge of any outstanding claims, licenses or other charges, liens, or encumbrances of any kind or nature whatsoever that could affect in any way Contractor's performance of this Agreement.

(2) DHCS MAKES NO WARRANTY THAT THE INTELLECTUAL PROPERTY RESULTING FROM THIS AGREEMENT DOES NOT INFRINGE UPON ANY PATENT, TRADEMARK, COPYRIGHT OR THE LIKE, NOW EXISTING OR SUBSEQUENTLY ISSUED.

g. Intellectual Property Indemnity

(1) Contractor shall indemnify, defend and hold harmless DHCS and its licensees and assignees, and its officers, directors, employees, agents, representatives, successors, and users of its products, ("Indemnitees") from and against all claims, actions, damages, losses, liabilities (or actions or proceedings with respect to any thereof), whether or not rightful, arising from any and all actions or claims by any third party or expenses related thereto (including, but not limited to, all legal expenses, court costs, and attorney's fees incurred in investigating, preparing, serving as a witness in, or defending against, any such claim, action, or proceeding, commenced or threatened) to which any of the Indemnitees may be subject, whether or not Contractor is a party to any pending or threatened litigation, which arise out of or are related to (i) the incorrectness or breach of any of the representations, warranties, covenants or agreements of Contractor pertaining to Intellectual Property; or (ii) any Intellectual Property infringement, or any other type of actual or alleged infringement claim, arising out of DHCS" use, reproduction, manufacture, sale, offer to sell, distribution, import, export, modification, public and private performance/display, license, and disposition of the Intellectual Property made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement. This indemnity obligation shall apply irrespective of whether the infringement claim is based on a patent, trademark or copyright registration that issued after the effective date of this Agreement. DHCS reserves the right to participate in and/or control, at Contractor's expense, any such infringement action brought against DHCS.

(2) Should any Intellectual Property licensed by the Contractor to DHCS under this Agreement become the subject of an Intellectual Property infringement claim, Contractor will exercise its authority reasonably and in good faith to preserve DHCS" right to use the licensed Intellectual Property in accordance with this Agreement at no expense to DHCS. DHCS shall have the right to monitor and appear through its own counsel (at Contractor's expense) in any such claim or action. In the defense or settlement of the claim, Contractor may obtain the right for DHCS to continue using the licensed Intellectual Property; or, replace or modify the licensed Intellectual Property so that the replaced or modified Intellectual Property becomes non-infringing provided that such replacement or modification is functionally equivalent to the original licensed Intellectual Property. If such remedies are not reasonably available, DHCS shall be entitled to a refund of all monies paid under this Agreement, without restriction or limitation of any other rights and remedies available at law or in equity.

(3) Contractor agrees that damages alone would be inadequate to compensate DHCS for breach of any term of this Intellectual Property Exhibit by Contractor. Contractor acknowledges DHCS would suffer irreparable harm in the event of such breach and agrees DHCS shall be entitled to obtain equitable relief, including without limitation an injunction, from a court of competent jurisdiction, without restriction or limitation of any other rights and remedies available at law or in equity.

h. Federal Funding

In any agreement funded in whole or in part by the federal government, DHCS may acquire and maintain the Intellectual Property rights, title, and ownership, which results directly or indirectly from the Agreement; except as provided in 37 Code of Federal Regulations part 401.14; however, the federal government shall have a non-exclusive, nontransferable, irrevocable, paid-up license throughout the world to use, duplicate, or dispose of such Intellectual Property throughout the world in any manner for governmental purposes and to have and permit others to do so.

i. Survival

The provisions set forth herein shall survive any termination or expiration of this Agreement or any project schedule.

11. Air or Water Pollution Requirements

Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR 15.5.

a. Government contractors agree to comply with all applicable standards, orders, or requirements issued under section 306 of the Clean Air Act [42 U.S.C. 1857(h)], section 508 of the Clean Water Act (33 U.S.C. 1368), Executive Order 11738, and Environmental Protection Agency regulations (40 CFR part 15).

b. Institutions of higher education, hospitals, nonprofit organizations and commercial businesses agree to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 U.S.C. 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 U.S.C. 1251 et seq.), as amended.

12. Prior Approval of Training Seminars, Workshops or Conferences

Contractor shall obtain prior DHCS approval of the location, costs, dates, agenda, instructors, instructional materials, and attendees at any reimbursable training seminar, workshop, or conference conducted pursuant to this Agreement and of any reimbursable publicity or educational materials to be made available for distribution. The Contractor shall acknowledge the support of the State whenever publicizing the work under this Agreement in any media. This provision does not apply to necessary staff meetings or training sessions held for the staff of the Contractor or Subcontractor to conduct routine business matters.

13. 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 Agreement 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 Agreement, 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 Agreement.

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 Agreement or authorized by the client, any such identifying information to anyone other than DHCS without prior written authorization from the DHCS Program Contract Manager, except if disclosure is required by State or Federal law.

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 Agreement or incorporated into this Agreement by reference.

14. Documents, Publications and Written Reports

(Applicable to agreements over $5,000 under which publications, written reports and documents are developed or produced. Government Code Section 7550.)

Any document, publication or written report (excluding progress reports, financial reports and normal contractual communications) prepared as a requirement of this Agreement shall contain, in a separate section preceding the main body of the document, the number and dollar amounts of all contracts or agreements and subcontracts relating to the preparation of such document or report, if the total cost for work by nonemployees of the State exceeds $5,000.

15. Dispute Resolution Process

a. A Contractor grievance exists whenever there is a dispute arising from DHCS" action in the administration of an agreement. If there is a dispute or grievance between the Contractor and DHCS, the Contractor must seek resolution using the procedure outlined below.

(1) The Contractor should first informally discuss the problem with the DHCS Program Contract Manager. If the problem cannot be resolved informally, the Contractor shall direct its grievance together with any evidence, in writing, to the program Branch Chief. The grievance shall state the issues in dispute, the legal authority or other basis for the Contractor's position and the remedy sought. The Branch Chief shall render a decision within ten (10) working days after receipt of the written grievance from the Contractor. The Branch Chief shall respond in writing to the Contractor indicating the decision and reasons therefore. If the Contractor disagrees with the Branch Chief's decision, the Contractor may appeal to the second level.

(2) When appealing to the second level, the Contractor must prepare an appeal indicating the reasons for disagreement with Branch Chief's decision. The Contractor shall include with the appeal a copy of the Contractor's original statement of dispute along with any supporting evidence and a copy of the Branch Chief's decision. The appeal shall be addressed to the Deputy Director of the division in which the branch is organized within ten (10) working days from receipt of the Branch Chief's decision. The Deputy Director of the division in which the branch is organized or his/her designee shall meet with the Contractor to review the issues raised. A written decision signed by the Deputy Director of the division in which the branch is organized or his/her designee shall be directed to the Contractor within twenty (20) working days of receipt of the Contractor's second level appeal.

b. If the Contractor wishes to appeal the decision of the Deputy Director of the division in which the branch is organized or his/her designee, the Contractor shall follow the procedures set forth in Health and Safety Code Section 100171.
(1)

c. Unless otherwise stipulated in writing by DHCS, all dispute, grievance and/or appeal correspondence shall be directed to the DHCS Program Contract Manager.

d. There are organizational differences within DHCS" funding programs and the management levels identified in this dispute resolution provision may not apply in every contractual situation. When a grievance is received and organizational differences exist, the Contractor shall be notified in writing by the DHCS Program Contract Manager of the level, name, and/or title of the appropriate management official that is responsible for issuing a decision at a given level.

16. Financial and Compliance Audit Requirements

a. The definitions used in this provision are contained in Section 38040 of the Health and Safety Code, which by this reference is made a part hereof.

b. Direct service contract means a contract or agreement for services contained in local assistance or subvention programs or both (see Health and Safety [H&S] Code Section 38020). Direct service contracts shall not include contracts, agreements, grants, or subventions to other governmental agencies or units of government nor contracts or agreements with regional centers or area agencies on aging (H&S Code Section 38030).

c. The Contractor, as indicated below, agrees to obtain one of the following audits:

(1) *If the Contractor is a nonprofit organization (as defined in H&S Code Section 38040)* and receives $25,000 or more from any State agency under a direct service contract or agreement; the Contractor agrees to obtain an annual single, organization wide, financial and compliance audit. Said audit shall be conducted according to Generally Accepted Auditing Standards. This audit does not fulfill the audit requirements of Paragraph c(3) below. The audit shall be completed by the 15th day of the fifth month following the end of the Contractor's fiscal year, and/or

(2) *If the Contractor is a nonprofit organization (as defined in H&S Code Section 38040)* and receives less than $25,000 per year from any State agency under a direct service contract or agreement, the Contractor agrees to obtain a biennial single, organization wide financial and compliance audit, unless there is evidence of fraud or other violation of state law in connection with this Agreement. This audit does not fulfill the audit requirements of Paragraph c(3) below. The audit shall be completed by the 15th day of the fifth month following the end of the Contractor's fiscal year, and/or

(3) *If the Contractor is a State or Local Government entity or Nonprofit organization (as defined by the Federal Office of Management and Budget [OMB] Circular A-133)* and expends $500,000 or more in Federal awards, the Contractor agrees to obtain an annual single, organization wide, financial and compliance audit according to the requirements specified in OMB Circular A-133 entitled "Audits of States, Local Governments, and Non-Profit Organizations". An audit conducted pursuant to this provision will fulfill the audit requirements outlined in Paragraphs c(1) and c(2) above. The audit shall be completed by the end of the ninth month following the end of the audit period. The requirements of this provision apply if:

(a) The Contractor is a recipient expending Federal awards received directly from Federal awarding agencies, or

(b) The Contractor is a subrecipient expending Federal awards received from a pass-through entity such as the State, County or community based organization.

(4) If the Contractor submits to DHCS a report of an audit other than an OMB A-133 audit, the Contractor must also submit a certification indicating the Contractor has not expended $500,000 or more in federal funds for the year covered by the audit report.

d. Two copies of the audit report shall be delivered to the DHCS program funding this Agreement. The audit report must identify the Contractor's legal name and the number assigned to this Agreement. The audit report shall be due within 30 days after the completion of the audit. Upon receipt of said audit report, the DHCS Program Contract Manager shall forward the audit report to DHCS" Audits and Investigations Unit if the audit report was submitted under Section 16.c(3), unless the audit report is from a City, County, or Special District within the State of California whereby the report will be retained by the funding program.

e. The cost of the audits described herein may be included in the funding for this Agreement up to the proportionate amount this Agreement represents of the Contractor's total revenue. The DHCS program funding this Agreement must provide advance written approval of the specific amount allowed for said audit expenses.

f. The State or its authorized designee, including the Bureau of State Audits, is responsible for conducting agreement performance audits which are not financial and compliance audits. Performance audits are defined by Generally Accepted Government Auditing Standards.

g. Nothing in this Agreement limits the State's responsibility or authority to enforce State law or regulations, procedures, or reporting requirements arising thereto.

h. Nothing in this provision limits the authority of the State to make audits of this Agreement, provided however, that if independent audits arranged for by the Contractor meet Generally Accepted Governmental Auditing Standards, the State shall rely on those audits and any additional audit work and shall build upon the work already done.

i. The State may, at its option, direct its own auditors to perform either of the audits described above. The Contractor will be given advance written notification, if the State chooses to exercise its option to perform said audits.

j. The Contractor shall include a clause in any agreement the Contractor enters into with the audit firm doing the single organization wide audit to provide access by the State or Federal Government to the working papers of the independent auditor who prepares the single organization wide audit for the Contractor.

k. Federal or state auditors shall have "expanded scope auditing" authority to conduct specific program audits during the same period in which a single organization wide audit is being performed, but the audit report has not been issued. The federal or state auditors shall review and have access to the current audit work being conducted and will not apply any testing or review procedures which have not been satisfied by previous audit work that has been completed.

The term "expanded scope auditing" is applied and defined in the U.S. General Accounting Office (GAO) issued Standards for *Audit of Government Organizations, Programs, Activities and Functions*, better known as the "yellow book".

17. Human Subjects Use Requirements

(Applicable only to federally funded agreements/grants in which performance, directly or through a subcontract/subaward, includes any tests or examination of materials derived from the human body.)

By signing this Agreement, Contractor agrees that if any performance under this Agreement or any subcontract or subagreement 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 U.S.C. Section 263a (CLIA) and the regulations thereunder.

18. Novation Requirements

If the Contractor proposes any novation agreement, DHCS shall act upon the proposal within 60 days after receipt of the written proposal. DHCS may review and consider the proposal, consult and negotiate with the Contractor, and accept or reject all or part of the proposal. Acceptance or rejection of the proposal may be made orally within the 60-day period and confirmed in writing within five days of said decision. Upon written acceptance of the proposal, DHCS will initiate an amendment to this Agreement to formally implement the approved proposal.

19. Debarment and Suspension Certification

(Applicable to all agreements funded in part or whole with federal funds.)

a. By signing this Agreement, the Contractor/Grantee agrees to comply with applicable federal suspension and debarment regulations including, but not limited to 7 CFR Part 3017, 45 CFR 76, 40 CFR 32 or 34 CFR 85.

b. By signing this Agreement, 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 application/proposal/agreement 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 Paragraph b(2) herein; and

(4) Have not within a three-year period preceding this application/proposal/agreement 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 part 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.

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 Contract Manager.

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 Agreement for cause or default.

20. Smoke-Free Workplace Certification

(Applicable to federally funded agreements/grants and subcontracts/subawards, that provide health, day care, early childhood development services, education or library services to children under 18 directly or through local governments.)

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 Agreement, Contractor or Grantee 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 or Grantee further agrees that it will insert this certification into any subawards (subcontracts or subgrants) entered into that provide for children's services as described in the Act.

21. Covenant Against Contingent Fees

(Applicable only to federally funded agreements.)

The Contractor warrants that no person or selling agency has been employed or retained to solicit/secure this Agreement 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 Agreement without liability or in its discretion to deduct from the Agreement price or consideration, or otherwise recover, the full amount of such commission, percentage, and brokerage or contingent fee.

22. Payment Withholds

(Applicable only if a final report is required by this Agreement. Not applicable to government entities.)

Unless waived or otherwise stipulated in this Agreement, DHCS may, at its discretion, withhold 10 percent (10%) of the face amount of the Agreement, 50 percent (50%) of the final invoice, or $3,000 whichever is greater, until DHCS receives a final report that meets the terms, conditions and/or scope of work requirements of this Agreement.

23. Performance Evaluation

(Not applicable to grant agreements.)

DHCS may, at its discretion, evaluate the performance of the Contractor at the conclusion of this Agreement. 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.

24. 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 Agreement, or to any benefit that may arise therefrom. This provision shall not be construed to extend to this Agreement if made with a corporation for its general benefits.

25. Four-Digit Date Compliance

(Applicable to agreements in which Information Technology (IT) services are provided to DHCS or if IT equipment is procured.)

Contractor warrants that it will provide only Four-Digit Date Compliant (as defined below) Deliverables and/or services to the State. “Four Digit Date compliant” Deliverables and services can accurately process, calculate, compare, and sequence date data, including without limitation date data arising out of or relating to leap years and changes in centuries. This warranty and representation is subject to the warranty terms and conditions of this Contract and does not limit the generality of warranty obligations set forth elsewhere herein.

26. Prohibited Use of State Funds for Software

(Applicable to agreements in which computer software is used in performance of the work.)

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 Agreement for the acquisition, operation or maintenance of computer software in violation of copyright laws.

27. Use of Small, Minority Owned and Women's Businesses

(Applicable to that portion of an agreement that is federally funded and entered into with institutions of higher education, hospitals, nonprofit organizations or commercial businesses.)

Positive efforts shall be made to use small businesses, minority-owned firms and women's business enterprises, whenever possible (i.e., procurement of goods and/or services). Contractors shall take all of the following steps to further this goal.

(1) Ensure that small businesses, minority-owned firms, and women's business enterprises are used to the fullest extent practicable.

(2) Make information on forthcoming purchasing and contracting opportunities available and arrange time frames for purchases and contracts to encourage and facilitate participation by small businesses, minority-owned firms, and women's business enterprises.

(3) Consider in the contract process whether firms competing for larger contracts intend to subcontract with small businesses, minority-owned firms, and women's business enterprises.

(4) Encourage contracting with consortiums of small businesses, minority-owned firms and women's business enterprises when a contract is too large for one of these firms to handle individually.

(5) Use the services and assistance, as appropriate, of such organizations as the Federal Small Business Administration and the U.S. Department of Commerce's Minority Business Development Agency in the solicitation and utilization of small businesses, minority-owned firms and women's business enterprises.

28. Alien Ineligibility Certification

(Applicable to sole proprietors entering federally funded agreements.)

By signing this Agreement, 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 U.S.C. 1601, et seq.)

29. Union Organizing

(Applicable only to grant agreements.)

Grantee, by signing this Agreement, hereby acknowledges the applicability of Government Code Sections 16645 through 16649 to this Agreement. Furthermore, Grantee, by signing this Agreement, hereby certifies that:

a. No state funds disbursed by this grant will be used to assist, promote or deter union organizing.

b. Grantee shall account for state funds disbursed for a specific expenditure by this grant, to show those funds were allocated to that expenditure.

c. Grantee shall, where state funds are not designated as described in b herein, allocate, on a pro-rata basis, all disbursements that support the grant program.

d. If Grantee makes expenditures to assist, promote or deter union organizing, Grantee will maintain records sufficient to show that no state funds were used for those expenditures, and that Grantee shall provide those records to the Attorney General upon request.

30. Contract Uniformity (Fringe Benefit Allowability)

(Applicable only to nonprofit organizations.)

Pursuant to the provisions of Article 7 (commencing with Section 100525) of Chapter 3 of Part 1 of Division 101 of the Health and Safety Code, DHCS sets forth the following policies, procedures, and guidelines regarding the reimbursement of fringe benefits.

a. As used herein fringe benefits shall mean an employment benefit given by one's employer to an employee in addition to one's regular or normal wages or salary.

b. As used herein, fringe benefits do not include:

(1) Compensation for personal services paid currently or accrued by the Contractor for services of employees rendered during the term of this Agreement, which is identified as regular or normal salaries and wages, annual leave, vacation, sick leave, holidays, jury duty and/or military leave/training.
(2) Director's and executive committee member's fees.
(3) Incentive awards and/or bonus incentive pay.
(4) Allowances for off-site pay.
(5) Location allowances.
(6) Hardship pay.
(7) Cost-of-living differentials

c. Specific allowable fringe benefits include:

(1) Fringe benefits in the form of employer contributions for the employer's portion of payroll taxes (i.e., FICA, SUI, SDI), employee health plans (i.e., health, dental and vision), unemployment insurance, worker's compensation insurance, and the employer's share of pension/retirement plans, provided they are granted in accordance with established written organization policies and meet all legal and Internal Revenue Service requirements.

d. To be an allowable fringe benefit, the cost must meet the following criteria:

(1) Be necessary and reasonable for the performance of the Agreement.
(2) Be determined in accordance with generally accepted accounting principles.
(3) Be consistent with policies that apply uniformly to all activities of the Contractor.

e. Contractor agrees that all fringe benefits shall be at actual cost.

f. Earned/Accrued Compensation

(1) Compensation for vacation, sick leave and holidays is limited to that amount earned/accrued within the agreement term. Unused vacation, sick leave and holidays earned from periods prior to the agreement term cannot be claimed as allowable costs. See Provision f (3)(a) for an example.

(2) For multiple year agreements, vacation and sick leave compensation, which is earned/accrued but not paid, due to employee(s) not taking time off may be carried over and claimed within the overall term of the multiple years of the Agreement. Holidays cannot be carried over from one agreement year to the next. See Provision f (3)(b) for an example.

(3) For single year agreements, vacation, sick leave and holiday compensation that is earned/accrued but not paid, due to employee(s) not taking time off within the term of the Agreement, cannot be claimed as an allowable cost. See Provision f (3)(c) for an example.

(a) Example No. 1:

If an employee, John Doe, earns/accrues three weeks of vacation and twelve days of sick leave each year, then that is the maximum amount that may be claimed during a one year agreement. If John Doe has five weeks of vacation and eighteen days of sick leave at the beginning of an agreement, the Contractor during a one-year budget period may only claim up to three weeks of vacation and twelve days of sick leave as actually used by the employee. Amounts earned/accrued in periods prior to the beginning of the Agreement are not an allowable cost.

(b) Example No. 2:

If during a three-year (multiple year) agreement, John Doe does not use his three weeks of vacation in year one, or his three weeks in year two, but he does actually use nine weeks in year three; the Contractor would be allowed to claim all nine weeks paid for in year three. The total compensation over the three-year period cannot exceed 156 weeks (3 x 52 weeks).

(c) Example No. 3:

If during a single year agreement, John Doe works fifty weeks and used one week of vacation and one week of sick leave and all fifty-two weeks have been billed to DHCS, the remaining unused two weeks of vacation and seven days of sick leave may not be claimed as an allowable cost.

31. Suspension or Stop Work Notification

a. DHCS may, at any time, issue a notice to suspend performance or stop work under this Agreement. The initial notification may be a verbal or written directive issued by the funding Program's Contract Manager. Upon receipt of said notice, the Contractor is to suspend and/or stop all, or any part, of the work called for by this Agreement.

b. Written confirmation of the suspension or stop work notification with directions as to what work (if not all) is to be suspended and how to proceed will be provided within 30 working days of the verbal notification. The suspension or stop work notification shall remain in effect until further written notice is received from DHCS. The resumption of work (in whole or part) will be at DHCS" discretion and upon receipt of written confirmation.

(1) Upon receipt of a suspension or stop work notification, the Contractor shall immediately comply with its terms and take all reasonable steps to minimize or halt the incurrence of costs allocable to the performance covered by the notification during the period of work suspension or stoppage.

(2) Within 90 days of the issuance of a suspension or stop work notification, DHCS shall either:

(a) Cancel, extend, or modify the suspension or stop work notification; or

(b) Terminate the Agreement as provided for in the Cancellation / Termination clause of the Agreement.

c. If a suspension or stop work notification issued under this clause is canceled or the period of suspension or any extension thereof is modified or expires, the Contractor may resume work only upon written concurrence of funding Program's Contract Manager.

d. If the suspension or stop work notification is cancelled and the Agreement resumes, changes to the services, deliverables, performance dates, and/or contract terms resulting from the suspension or stop work notification shall require an amendment to the Agreement.

e. If a suspension or stop work notification is not canceled and the Agreement is cancelled or terminated pursuant to the provision entitled Cancellation / Termination, DHCS shall allow reasonable costs resulting from the suspension or stop work notification in arriving at the settlement costs.

f. DHCS shall not be liable to the Contractor for loss of profits because of any suspension or stop work notification issued under this clause.

32. Lobbying Restrictions and Disclosure Certification

(Applicable to federally funded agreements in excess of $100,000 per Section 1352 of the 31, U.S.C.)

a. Certification and Disclosure Requirements

(1) Each person (or recipient) who requests or receives a contract or agreement, 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 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 affect 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 or agreement, subcontract, grant or subgrant exceeding $100,000 at any tier under a contract or agreement, 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.

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 or agreement, grant, loan, or cooperative agreement to pay any person for

Attachment 1

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 or agreement, 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 or agreement, grant, loan, or cooperative agreement.

Attachment 1

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:

California Department of Health Care Services

DHCS reserves the right to notify the contractor in writing of an alternate submission address.

Attachment 2

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: [ ] a. contract b. grant c. cooperative agreement d. loan e. loan guarantee f. loan insurance	2. Status of Federal Action: [ ] a. bid/offer/application b. initial award c. post-award	3. Report Type: [ ] a. initial filing b. 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	7. 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 Registrant *(If individual, last name, first name, MI)*:	b. Individuals Performing Services *(including address if different from 10a.* *(Last name, First name, MI):*
11. 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 31 U.S.C. 1352. This information will be available for public inspection. Any person that fails to file the required disclosure shall be subject to a 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 (Rev. 7-97)

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 recipient, 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. 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 followup 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 itis, 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 (CFDA) 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-90-001".

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 registrant under the Lobbying Disclosure Act of 1995 engaged by the reporting entity identified in item 4 to influence the covered Federal action.

    (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. The certifying official shall sign and date the form, print his/her name, title, and telephone number.

According to the Paperwork Reduction Act, as amended, no persons are required to respond to a collection of information unless it displays a valid OMB Control Number. The valid OMB control number for this information collection is OMB No. 0348-0046. Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing 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

a. The following additional exhibits are attached, incorporated herein, and made a part hereof by this reference:

1) Exhibit G HIPAA Business Associate Addendum

2) Narrative Proposal Submitted by the Contractor.

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.

2. Amendment Process

In addition to Exhibit C, Provision 2, Amendment, Contractor also agrees to the following:

Should either party, during the term of this Agreement, desire a change or amendment to the terms of this Agreement, such changes or amendments shall be proposed in writing to the other party, who will respond in writing as to whether the proposed changes/amendments are accepted or rejected. If accepted and after negotiations are concluded, the agreed upon changes shall be made through the State's official agreement amendment process, unless otherwise stipulated within this Agreement. No amendment will be considered binding on either party until it is formally approved by both parties and the Department of General Services (DGS), if DGS approval is required.

3. Termination

a. Termination without Cause – State

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 six (6) months prior to the effective date of termination.

b. Termination with Cause – State

1) DHCS shall terminate this contract pursuant to the provisions of Welfare and Institutions Code Section 14304(a) and 22 CCR 53352.

2) **42 CFR § 438.708 provides that DHCS may terminate a contract and enroll that Contractor's Members in other DMC plans or provide their benefits through other options included in DHCS' plan if DHCS determines that the Contractor has failed to carry out substantive terms of the contract, or meet applicable requirements in sections 1932, 1903(m), and 1905(t) of the Social Security Act.**

3) **42 CFR § 438.710 requires that DHCS must provide the Contractor a pre-termination hearing before terminating the contract under 42 CFR § 438.708.**

4) 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 finds that the Contractor no longer 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.

5) 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.

6) DHCS shall terminate the contract for Contractor's non-compliance with CAP recommendations agreed upon by the Contractor and DHCS.

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 six (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 detailed written financial analysis to DHCS supporting its conclusions that it cannot remain financially solvent. At the request of DHCS, Contractor 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 17.

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. Termination under this section does not relieve Contractor of its contract termination obligations under Provision 17, Phaseout Requirements, which shall be performed after contract termination.

e. Notice to Members of Transfer of Care

At least sixty (60) calendar days prior to the termination of the contract, DHCS will notify Members about their dental benefits and available options.

f. Prohibited Contracts due to Termination

Any contractor terminated by the State during the life of the contract shall be prohibited from participating in the next dental Request for Application (RFA) or dental Request for Proposal (RFP) procurement.

g. **Notice of ~~Sanctions and~~ Pre-Termination Hearing**

~~**Except as provided in 42 CFR §438.706(c), 42 CFR § 438.710 provides that before imposing any of the intermediate sanctions specified, the State must give the affected entity timely written notice that explains the basis and nature of the action and any other appeal rights the state has elected to provide. and must provide the entity a pre-termination hearing.**~~

The State must:

1. **Provide the contractor written notification of its intent to terminate, the reason for termination, and the time and place of the hearing;**
2. **After the hearing, give the contractor written notice of the decision either affirming or reversing the proposed termination of the contract and, for an affirming decision, the effective date of termination; and**
3. **For an affirming decision, DHCS shall provide contractor's members notice of the termination and information, consistent with 42 CFR § 438.10, on members' options for receiving Medicaid services following the effective date of termination.**

After notifying the Contractor of DHCS' intent to terminate the contract, DHCS may give the Contractor's Members written notice of DHCS' intent to terminate, and to allow Members to disenroll immediately without cause.

h. **Special Rules for Temporary Management**

The State may impose temporary management if it finds there is:

1. **Continued egregious behavior by the contractor, including, but not limited to, behavior that is described in 42 CFR § 438.700, or that is contrary to any requirements of sections 1903(m) and 1932 of the Social Security Act,**
2. **There is a substantial risk to members' health, or**
3. **If it is necessary to ensure the health of members.**

i. **Required Imposition of Sanction**

The State may impose temporary management (regardless of any other sanction that may be imposed) if it finds that the Contractor has repeatedly failed to meet substantive requirements in sections 1903(m) or 1932 of the Act.

The State may not delay imposition to provide a hearing or terminate temporary management until the Contractor can ensure that the sanctioned behavior will not recur.

4. Dispute Resolution Process

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 fifteen (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.

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 Dental 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 thirty (30) calendar days of receipt of a Notification of Dispute, the Contracting Officer or the alternate dispute officer shall either:

d. Find in favor of Contractor, in which case the Contracting Officer or alternate dispute officer may:

1) Countermand the earlier conduct which caused Contractor to file a dispute; or

2) Reaffirm the conduct and, if there is a cost impact sufficient to constitute a change in obligations pursuant to the payment provisions contained in Exhibit B, Budget Detail and Payment, direct DHCS to comply with that Exhibit.
Or,

e. Deny Contractor's dispute and, where necessary, direct the manner of future performance; or

f. 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 thirty (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 thirty (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 i. Waiver of Claims, below.

A copy of the decision shall be served on Contractor.

g. Appeal of Contracting Officer's or Alternate Dispute Officer's Decision

Contractor shall have thirty (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 i, Waiver of Claims below, Contractor shall exhaust all procedures provided for in this Provision 4, Dispute Resolution Process, prior to initiating any other action to enforce this Contract.

h. 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 g. 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 g. 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**, or any subsequent court decision or court order regarding the subject matter of the Notification of Dispute.**

i. 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 4, Dispute Resolution Process, that failure shall constitute a waiver by Contractor of all claims arising out of that conduct, whether direct or consequential in nature.

5. 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 3, Subprovision c, Termination Without Cause -

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 Plan Letters issued by Medi-Cal Dental Services Division (MDSD), Dental Managed Care (DMC) are hereby incorporated into this contract and shall be complied with by Contractor. All Plan Letters issued by MDSD subsequent to the 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 an All Plan Letter, the All Plan Letter shall prevail.

6. Entire Agreement

This written contract and all documents incorporated by reference shall constitute the entire agreement between the parties. No verbal representations shall be binding on either party unless such representations are reduced to writing in an All Plan Letter, Change Order or made an amendment to the contract consistent with Exhibit E, Additional Provisions, Provision 2, Amendment Process

7. Assignment/Transfer of Contract

This contract shall not be assigned or otherwise transferred, in whole or in part, without the express written consent of DHCS and amendment of the Contract. Contractor acknowledges that DHCS may not grant such consent, within six (6) months after this Contract's effective date or within six (6) months prior to its expiration date.

8. 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 development of a system which has the capability to implement such changes in an orderly and timely manner is of considerable importance. Such changes shall be implemented by amendment to this contract in accordance with Exhibit E, Additional Provisions, Provision 2, Amendment Process.

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 contract amendment. If DHCS issues a contract amendment, 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 contract amendments 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.

d. Adhoc Reporting

During the life of this contract, DHCS reserves the right to submit written requests to the Contractor for additional Adhoc reports. Contractor must provide a written acknowledgement of the request within the required timeframe set by DHCS.

9. 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, Additional Provisions, Provision 13, 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.

10. 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 Dental 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 Dental 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.

11. 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.

12. 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~~ **Chief Executive Officer (CEO), Chief Financial Officer (CFO)** 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 compliance with legal and contractual requirements to the best of that individual's knowledge and belief. **The CEO and CFO are ultimately responsible for the certification.**

13. 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
Chief, Medi-Cal Dental Services Division
MS 4900, P.O. Box 997413
Sacramento, CA 95899-7413
~~11155 International Drive, Bldg. C~~
~~Rancho Cordova, CA 95670~~

Contractor Name and Address
Attn: Contractor Representative

14. Term

a. The contract will become effective January 1, 2013, and will continue in full force and effect through July 31, 2016 subject to the provisions of Exhibit B, Provision A, Budget Contingency Clause and Exhibit D(F), Provision 9, Federal Contract Funds.

b. The term of the contract consists of the following three periods:

1) The Implementation Period, which ends as of the effective date of this contract;

2) The Operations Period shall commence at the conclusion of the Implementation Period, January 1, 2013 through December 31, 2015, 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 3, Termination, and Provision 18,

Sanctions, and subject to the limitation provisions of Exhibit B, Provision A, Budget Contingency Clause and Exhibit D(F); and;

3) The Phase-out Period shall extend for seven (7) months from the end of the Operations Period or contract extension 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 3, Termination, and Provision 18, Sanctions, below and subject to the limitation provisions of Exhibit B, Provision A, Budget Contingency Clause. The Phaseout Period shall extend for seven (7) months from the end of the Operations Period, subject to Provision 15, Contract Extension, below, in which case the Phaseout Period shall begin with the first day after the end of the Extension Period and continue for seven (7) months.

15. Contract Extension

DHCS will have the exclusive option to extend the term of the Contract during the last twelve (12) 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 (12) 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.

Contractor will provide written notification to DHCS of its intent to accept or reject the extension within ten (10) business days of the receipt of the notice from DHCS.

16. Service Area

The Service Area covered under this Contract includes:

Sacramento County

17. Phaseout Requirements

a. DHCS shall retain a phaseout withhold, equal to the lesser amount of either 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 phaseout withhold amount 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.

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 (90) 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 dental 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.

e. Contractor shall submit a final undisputed payment invoice as soon as practical, following this contract's expiration or termination date, but no later than seven (7) months following the expiration or termination date of this contract, unless a later or alternate deadline is accepted in writing by DHCS in response to a request submitted by Contractor prior to this contract's expiration or termination date. The invoice must be clearly marked "Final Invoice" and accompanied by the Contractor's Release form in Exhibit F, to indicate that all payment obligations of DHCS under this contract have been fulfilled and no further payments are due or outstanding.

   DHCS, at its discretion, may elect not to honor any delinquent final invoice if the Contractor fails to obtain prior written DHCS acceptance of an alternate final invoice submission deadline.

18. Sanctions

Contractor is subject to sanctions and civil penalties taken pursuant to Welfare and Institutions 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 activities, which may include, but are not limited to, referrals, assignment of beneficiaries, and reporting, until DHCS determines that Contractor is again in compliance. **Except as provided in 42 CFR 438.706(c), 42 CFR 438.710 provides that before imposing any of the intermediate sanctions specified, DHCS must give the affected entity timely written notice that explains the basis and nature of the action and any other appeal rights the state has elected to provide.**

a. **Determination of non-compliance may be based on findings from onsite surveys, enrollee or other complaints, financial status, or any other source.** 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. A contractor may request a hearing in connection with any sanctions applied pursuant to Welfare and Institutions Code Section 14304(b) in addition to temporary suspension orders within 15 working days of notice by sending a letter to the address in said notice. DHCS shall stay implementation of the sanction upon receipt of the request for a hearing. Implementation shall remain stayed until the effective date of DHCS's final determination.

c. Sanctions for violations of the requirements of Exhibit A, Attachment 5, Quality Improvement System, shall be governed by Subsection 53872 (b)(4).

d. For purposes of sanctions, good cause includes, but is not limited to, the following:

   1) Three (3) repeated and uncorrected findings of serious deficiencies that have the potential to endanger patient care identified in the dental audits conducted by DHCS.

   2) In the case of Exhibit A, Attachment 6, Performance Measures and Benchmarks, the Contractor consistently fails to achieve the minimum performance benchmarks, or receives a "Not Reported" designation on a performance measure, after implementation of corrective actions.

   3) A substantial failure to provide medically necessary covered services required under this contract or law to a Member.

   4) Imposition on Members of premiums or charges that are in excess of the premiums or charges permitted under the Medi-Cal program.

   5) Acts to discriminate among Members on the basis of their health status or need for services, including both termination of existing enrollment and refusal or discouragement of (re)enrollment.

   6) Misrepresentation or falsification of information furnished to CMS or to DHCS.

   7) Misrepresentation or falsification of information furnished to a Member, potential Member, or health care provider.

   8) Non-compliance with the contract or applicable Federal and State law or regulation.

   9) Violation of any of the requirements under sections 1903(m) or 1932 of the Social Security Act.

10) Failure to comply with requirements for physician incentive plans as set forth in 42 CFR 422.208 and 422.210.

11) The direct or indirect distribution of marketing materials that have not been approved by DHCS, or that contain false or materially misleading information.

12) Contractor has accrued claims that have not or will not be recompensed.

d. Upon determinations of non-compliance, DHCS may impose the following sanctions:

1) Granting and notification of Members the right to terminate enrollment without cause.

2) Suspension of all new enrollment after the date the Contractor is notified of a violation under sections 1903(m) or 1932 of the Social Security Act.

3) Suspension of payment for Members enrolled after the effective date of the sanction and until CMS or DHCS is satisfied that the basis for the sanction no longer exists and is not likely to recur.

e. The following intermediate sanctions may be imposed due to lack of compliance in all cases except for violations of sections 1903(m) or 1932 of the Social Security Act.

1) Civil money penalties pursuant as provided in this Provision.

2) Appointment of temporary management as provided in Provision 3.

f. DHCS retains authority to impose additional sanctions under State statutes or State regulations that address areas of noncompliance specified in 42 CFR 438.700, as well as additional areas of noncompliance. Nothing in this subpart prevents DHCS from exercising that authority.

g. DHCS may make one or more of the following temporary suspension orders as an immediate sanction, effective no earlier than 20 days after the notice:

1) Suspend marketing activities.

2) Require the contractor temporarily to suspend specified personnel.

3) Require the contractor temporarily to suspend participation by a specified subcontractor.

h. Upon receipt of a notifice of defense filed by the contractor, DHCS shall within 15 days set the matter for hearing, no later than 30 days after the receipt of the notice of hearing by the contractor. The temporary suspension order shall remain in effect until the hearing is completed and DHCS has made a final determination. The temporary suspension order shall be deemed vacated if the Director fails to make a final determination on the merits within 60 days after the original hearing has been completed.

i. Sanctions in the form of denial of payments provided for under this 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.

j. **The imposition of civil penalties shall be limited depending on the nature of the Contractor's non-compliance in accordance with applicable Federal and State law or regulation.**

1) **The limit is twenty-five thousand dollars ($25,000) for each determination of failure to provide medically necessary services; misrepresentation of information furnished to Members, potential Members, or health providers; failure to comply with physician incentive plan requirements; and the distribution of unapproved or inaccurate marketing materials.**

2) **The limit is one hundred thousand dollars ($100,000) for each determination of discrimination among Members on the basis of their health status or health care needs; and the misrepresentation of information furnished to CMS or DHCS.**

3) **The limit is fifteen thousand dollars ($15,000) for each beneficiary the State determines was not enrolled due to discriminatory practices.**

4) **The limit is twenty-five thousand dollars ($25,000) or double the amount of the excess charges for each determination of that Members' premiums or charges are in excess of the premiums or charges permitted under Medi-Cal.**

k. 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) **Impose additional civil penalties if the Contractor violates any federal or state statute or regulation, or any provision of its contract with DHCS, as follows:**

a) **Five thousand dollars ($5,000) for the first violation.**
b) **Ten thousand dollars ($10,000) for the second violation.**
c) **The limit is twenty-five thousand dollars ($25,000) for each subsequent violation.**

5) **Collect civil penalties by withholding the amount from capitation owed to the Contractor.**

6) Take other appropriate action as determined necessary by DHCS.

19. Liquidated Damages Provisions

a. General

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 within thirty (30) calendar days of notice;

   c) Additional damages may occur in specified areas by prolonged periods in which Contractor does not provide or perform requirements;

   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 Subprovision 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 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 five (5) business 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 thirty (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 five (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 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 thirty (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 14, 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

   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 5, Quality Improvement System, Provision K, Site Review, until the contract requirement is performed or provided.

   2) Third-Party Tort Liability

      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 Provision 25, Third-Party Tort Liability.

   3) Plan Provider Availability

      DHCS may impose liquidated damages of $3,500 per violation of contract requirement not performed in accordance with Exhibit A, Attachment 8, Provider Network, Provision F, Adequate Facilities and Personnel.

   4) Security and Confidentiality

      DHCS may impose liquidated damages of $2,500 per day, until Contractor has corrected the deficiency, if Contractor fails to comply with Exhibit A, Attachment 4, Management Information System, Provision D, HIPAA requirements.

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 ninety (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.

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.

20. 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 subcontracts, working papers; reports submitted to DHCS; financial records; all dental records, charts and prescription files; and other documentation pertaining to dental and non-dental services rendered to Members.

b. Records Retention

Notwithstanding any other records retention time period set forth in this contract, **Contractor shall retain, and require subcontractors to retain** these books and records**, including member grievance and appeal records in 42 CFR § 438.416, base data in 42 CFR §438.5(c), MLR reports in 42 CFR §438.8(k), and the data, information, and documentation specified in 42 CFR §§ 438.604, 438.606, 438.608, and 438.610** ~~will be maintained~~ for a minimum of ~~five (5)~~ **ten (10)** 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.

21. Monitoring Requirements

a. The Contractor must comply with any State-conducted readiness review.

b. Readiness reviews must include both a desk review of documents and on-site reviews of the Contractor. Readiness reviews described in paragraph c of this section must include a desk review of documents and may, at DHCS's option, include an on-site review. On-site reviews must include interviews with the Contractor staff and leadership that manage key operational areas.

c. The DHCS readiness review will assess the ability and capacity of Contractor (if applicable) to perform satisfactorily for the following areas:

1) Operations/Administration, including:

a) Administrative staffing and resources.
b) Delegation and oversight of MCO, PIHP, PAHP or PCCM entity responsibilities.
c) Member and provider communications.
d) Grievance and appeals.
e) Member services and outreach.
f) Provider Network Management.
g) Program Integrity/Compliance.

2) Service delivery, including:

a) Case management/care coordination/service planning.
b) Quality improvement.
c) Utilization review.

3) Financial management, including:

a) Financial reporting and monitoring.
b) Financial solvency.

4) Systems management, including:

a) Claims management.
b) Encounter data and enrollment information management.

22. ~~21.~~ 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 20, 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, 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, dental records, prescription files, subcontracts, information systems and procedures, and any other documentation pertaining to dental and non-dental 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.

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).

23. ~~22.~~ 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 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 dental records in accordance with applicable law pertaining to the release of this type of information. Contractor is not required to report requests for dental 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 dental 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.

24. ~~23.~~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, Additional Provisions, Provision 2, Amendment Process.

25. ~~24.~~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 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 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 fee-for-service 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 pediatric preventive 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 fee-for-service basis, Contractor shall pay for services provided to a Member 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 ten (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.

26. ~~25.~~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 within ten (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 thirty (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) Medi-Cal Beneficiary Identification Number

4) Date of birth

5) Contractor name

6) Provider name (if different from Contractor)

7) Dates of service

8) 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)

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~~**MS 4720, P.O. Box 997425, Sacramento, CA 95899-7425**.

27. ~~**26.**~~**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.

b. Payment for Records

In addition to the payments provided for in Exhibit B, Budget Detail and Payment, 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 ten (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.

28. ~~27.~~Fraud, Waste, and Abuse

a. For purposes of this provision, see Exhibit E, Attachment 1, Definitions, for abuse, conviction or convicted and fraud.

b. Contractor shall meet the requirements set forth in 42 CFR § 438.608 **as well as applicable state and federal law**. Contractor shall establish an Anti-Fraud and Abuse **Compliance** Program in which there will be **written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable Federal and State standards. Contractor or subcontractor will designate a Compliance Officer as** a central point of contact for all fraud and/or abuse issues**, who reports to the Chief Executive Officer and board of directors**. This program will establish policies and procedures for identifying, investigating and taking appropriate action against fraud and/or abuse in the provision of health care services under the Medi-Cal Program.

1) Regulatory Compliance

Contractor shall establish a compliance committee on the board of directors that are accountable to senior management for overseeing the compliance program and who will be responsible for the following:

a) Effective training and education for the Compliance Officer and the organization's employees.

b) Effective lines of communication between the Compliance Officer and the organization's employees.
Enforcement of standards through well-publicized disciplinary guidelines.

~~c)~~ ~~Provision for internal monitoring and auditing~~. Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the contract.

d) Provision for prompt response to detected offenses, and for development of corrective action initiatives.

~~1)~~ **2)** Fraud**, Waste,** and Abuse Reporting

Contractor shall report to DHCS all cases of suspected Fraud**, Waste,** and/or Abuse where there is reason to believe that an incident of Fraud**, Waste,** and/or Abuse has occurred by subcontractors, members, providers, or employees. Contractor shall conduct, complete, and **promptly** report to DHCS, the results of a preliminary investigation of the suspected Fraud**, Waste,** and/or Abuse within ten (10) business days of the date Contractor first becomes aware of, or is on notice of, such activity. **The contractor shall promptly refer any identified potential fraud, waste, or abuse to DHCS' Medicaid program integrity unit/fraud control unit for DMC plans.** The preliminary investigation and all documents regarding the investigation shall be reviewed by a licensed dentist.

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:

i. Name and/or SSN or CIN;
ii. Source of complaint;
iii. Type of provider (if applicable);
iv. Nature of complaint;
v. Approximate dollars involved; and
vi. Legal and administrative disposition of the case.

The report shall be submitted on a Confidential Medi-Cal Complaint Report and mailed to DHCS at:

Department of Health Care Services
Medi-Cal Dental Services Division
P.O. Box 997413, Mail Stop ~~4708~~**4900**
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 the provider, pharmaceutical data from manufacturers, wholesalers and retailers and any other pertinent information.

Network providers for which the State determines there is a credible allegation of fraud shall be subjected to a suspension in payments in accordance with 42 CFR § 455.23

Contractor employees shall be given written policies regarding the False Claims Act and about their rights to be protected as whistleblowers.

3) Overpayments Recovery

Contractor shall promptly report to DHCS in accordance with Exhibit E, Additional Provisions, Provision 28, Fraud, Waste, and Abuse Reporting all overpayments identified or recovered, specifying the overpayments due to potential fraud.

Contractor shall comply with 42 CFR § 438.608(d). Recoveries of overpayments to network providers due to fraud, waste, or abuse shall be reported to DHCS by the Contractor on an annual basis, including the provider name, nature of overpayment, and dollar amount for each occurrence. Contractor shall require network providers to immediately report when they have received an overpayment, ~~and~~ return the overpayment within sixty (60) calendar days from discovery of the overpayment, and notify the Contractor in writing of the reason for the overpayment. Treatment of recoveries of overpayments to DHCS shall be in accordance with Exhibit B, Budget Detail and Payment Provisions, Provision J.

4) Changes in Eligibility

Contractor shall promptly report to DHCS in accordance with Exhibit E, Additional Provisions, Provision 28, Fraud, Waste, and Abuse Reporting when it receives information about changes in a Member's circumstances that may affect the Member's eligibility including all of the following:

a) Changes in the Member's residence.

b) The death of a Member.

5) Delivery of Services

Contractor shall comply with 42 CFR § 438.608(a)(5). Contractor must implement and maintain arrangements or procedures that include provisions to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by Members. Contractor shall apply such verification processes on a regular basis.

~~2)~~ **~~4)~~ 6)** Tracking Suspended Providers

Contractor shall comply with 42 CFR 438.610. Additionally, Contractor is prohibited from employing, contracting or maintaining a contract with Dentists or other dental 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); by the Department of Health and Human Services, Office of Inspector General, List of Excluded Individuals and Entities (http://oig.hhs.gov); by the Excluded Parties List System (http://www.epls.gov); and provider shall not be found on the Social Security Administration's Death Master File (http://www.ssdmf.com). Contractor is deemed to have knowledge of any providers on these lists. Contractor must notify the Medi-Cal Dental Managed Care Unit within ten (10) state business 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.

~~3)~~ ~~5)~~ 7) 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.

29. ~~28.~~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).

30. ~~29.~~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 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 1972 (regarding education programs and activities); 45 CFR 91 the Age Discrimination Act of 1975; and all other laws regarding privacy and confidentiality.

31. ~~30.~~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.

32. ~~31.~~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.

EXHIBIT E, ATTACHMENT 1
DEFINITIONS

As used in this contract or other DHCS Medi-Cal Dental Managed Care contract, unless otherwise expressly provided or the context otherwise requires, the following definitions of terms will govern the construction of this contract:

Abuse means provider practices that are inconsistent with sound fiscal, business, or dental practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for dental 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 Welf. & Inst. Code §14043.1(a).

Actuary means an individual who meets the qualification standards established by the American Academy of Actuaries for an actuary and follows the practice standards established by the Actuarial Standards Board. In this part, Actuary refers to an individual who is acting on behalf of the State when used in reference to the development and certification of capitation rates as defined in 42 CFR § 438.2

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 dental care services, which would ordinarily be incurred in the provision of these services whether or not through a plan.

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.

All Plan Letter means a document that is dated, numbered and issued by DHCS to provide clarification of Contractor 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

Beneficiary Assignment means the act of Department of Health Care Services (DHCS) or DHCS' enrollment contractor of notifying a beneficiary in writing of the plan in which the beneficiary shall be enrolled if the beneficiary fails to timely choose a plan. If, at any time, the beneficiary notifies DHCS or DHCS' enrollment contractor of the beneficiary's plan choice, such choice shall override the Beneficiary Assignment and be effective as provided in Exhibit A, Attachment 16, Enrollments and Disenrollments, Provision B.

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 plan enrollment.

Business day(s) means any day that the Contractor and/or State is open for business.

California Children's 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's Services (CCS) Eligible Conditions means a physically handicapping condition defined in Title 22, California Code of Regulations (CCR), Section 41410.

California Children's 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.

Capitation means the method of payment in which the Contractor is paid by the State, or subcontractor is paid by Contractor, a fixed amount for a Member over a given period regardless of the actual number or nature of services delivered.

Capitation payment means a payment the State makes periodically to a contractor on behalf of each beneficiary enrolled under a contract and based on the actuarially sound capitation rate for the provision of services under the State plan. The State makes the payment regardless of whether the particular beneficiary receives services during the period covered by the payment as defined in 42 CFR § 438.2

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 Members 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.

Case Management means services provided by a Primary Care Dentist to ensure the coordination of medical necessary dental services, assuring the provision of preventative services in accordance with established standards and ensuring continuity of care for Medi-Cal Members. It includes treatment, planning, coordination referral, follow-up, and monitoring of appropriate services and resources required to meet an individual's dental care needs.

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 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)."

Choice counseling means the provision of information and services designed to assist beneficiaries in making enrollment decisions; it includes answering questions and identifying factors to consider when choosing among managed care plans and primary care providers. Choice counseling does not include making recommendations for or against enrollment into a specific MCO, PIHP, or PAHP.

Comprehensive risk contract means a risk contract between the State and an MCO that covers comprehensive services, that is, inpatient hospital services and any of the following services, or any three or more of the following services:

(1) Outpatient hospital services.
(2) Rural health clinic services.
(3) Federally Qualified Health Center (FQHC) services.

(4) Other laboratory and X-ray services.
(5) Nursing facility (NF) services.
(6) Early and periodic screening, diagnostic, and treatment (EPSDT) services.
(7) Family planning services.
(8) Physician services.
(9) Home health services.

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.

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 Welfare and Institutions Code Section 14043.1(f)**.**

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 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 identified by formal audits or monitoring activities by the State or its designated representatives.

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.

Covered Services means Dental Case Management and those benefits set forth in Welfare and Institutions Code Section 14132(h), 22 CCR 51059, and 51003.

Credentialing means the recognition of professional or technical competence. The process involved may include registration, certification, licensure and professional association membership.

Dental Records means written documentary evidence of dental treatments rendered to Contractor's Members.

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/Denti-Cal in California) Program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disability Prevention Program (CHDP), and other 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.

Director means the Director of the State of California Department of Health Care Services.

Eligible Beneficiary means any Medi-Cal beneficiary who is residing in the Contractor's Service Area and has met all the qualifications with one of the following aid codes:

Aid Group	Mandatory Aid Codes	Non-Mandatory Aid Codes
Family	01, 02, 08, 0A, 0G, 30, 32, 33, 34, 35, 38, 39, 3A, 3C, 3E, 3F, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 47, 54, 59, 5V, 72, 7A, 7L, 7S, 7W, 7X, 82, 8P, 8R, E6, E7, K1, L6, M7,	03, 04, 07, 40, 42, 43, 45, 49, 4A, 4E, 4F, 4G, 4H, 4K, 4L, 4M, 4N, 4S, 4T, 4W, 5K, 7J
Adult Expansion	7U, E2, E5, L1, M1, M3, M5, P5, P7, P9, T1, T2, T3, T4, T5	
Aged		06, 10, 14, 16, 46, 1E, 1H
Disabled		20, 24, 26, 2E, 2H, 36, 60, 64, 66, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6V
Adult		86
Child	5C, 5D, H1, H2, H3, H4, H5	
Breast and Cervical Cancer Treatment Program (BCCTP)		0N, 0P, 0W

Emergency Dental Condition means a dental condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of dentistry could reasonably expect the absence of immediate dental attention to result in:

A. Placing the patient's health (or in the case of pregnant woman, the health of the woman or unborn child) in serious jeopardy, such as:

   1) High risk-to-life or seriously disabling conditions such as cellulitis, oral hemorrhage, and trauma.
   2) Low risk-to-life or minimally disabling conditions such as painful low-grade oral infections, near pulpal exposures, or fractured teeth.

B. Serious impairment to bodily function.

C. Serious dysfunction of any bodily organ or part.

Emergency Services means Covered Services that are furnished by a Provider that is qualified to furnish those services needed to evaluate or stabilize an Emergency Dental Condition.

Encounter means any single face-to-face dentally related service rendered by a dental Provider(s) to a Member enrolled in the plan during the date of service. It includes, but is not limited to, all services for which the Contractor incurred any financial liability.

Enrollee means a Medicaid beneficiary who is currently enrolled in an MCO, PIHP, PAHP, PCCM, or PCCM entity in a given managed care program.

Enrollee Encounter Data means the information relating to the receipt of any item(s) or service(s) by an enrollee under a contract between a State and a MCO, PIHP, or PAHP that is subject to the requirements of 42 CFR § 438.242 and 438.818.

Enrollment means the process by which an Eligible Beneficiary becomes a Member of the Contractor's plan.

Facility means any Service Location or premise that is:

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 HMO means an HMO that CMS has determined is a qualified HMO under section 1310(d) of the PHS Act. Fraud has the same meaning as the term is defined in 42 CFR § 455.2.

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.

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.

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; Welf. & Inst. Code §14043.1(i).)

Geographic Managed Care (GMC) Program means the Medi-Cal Dental GMC Program authorized by Section 14089 et seq. of the Welfare and Institutions Code.

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.

Implementation Period means the timeframe from contract effective date to the beginning of the Operations period.

Indian Health Care Provider ~~Service~~ (IHCP~~S~~) ~~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. (22 CCR 55000.)~~ **a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603 & 42 CFR §§ 438.2, § 438.14.)**

Knox-Keene Health Care Service Plan Act of 1975 means the law that regulates Health Maintenance Organizations (HMO) specialized health care (dental) plans and is administrated by the Department of Managed Health Care, commencing with Section 1340, Health and Safety Code.

Managed care organization (MCO) means an entity that has, or is seeking to qualify for, a comprehensive risk contract under this part and that is:

1. **A Federally qualified HMO that meets the advance directives requirements of subpart I of part 489 of this chapter; or**
2. **Any public or private entity that meets the advance directives requirements and is determined by the Secretary to also meet the following conditions:**
    a) **Makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the area served by the entity.**

b) Meets the solvency standards of 42 CFR § 438.116.

Managed care program means a managed care delivery system operated by the State as authorized under sections 1915(a), 1915(b), 1932(a), or 1115(a) of the Act.

Material adjustment means an adjustment that, using reasonable actuarial judgment, has a significant impact on the development of the capitation payment such that its omission or misstatement could impact a determination whether the development of the capitation rate is consistent with generally accepted actuarial principles and practices.

Marketing means any activity conducted on behalf of the Contractor where information regarding the services offered by the Contractor is disseminated in order to persuade Eligible Beneficiaries to enroll. Marketing also includes any similar activity to secure the endorsement of any individual or organization on behalf of the Contractor.

Marketing Representative means a person who is engaged in marketing activities on behalf of the Contractor.

Measurement Year means the timeframe beginning January 1st and continuing for twelve (12) months.

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.

Medically Necessary Dental Covered Services means reasonable and necessary Covered 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. (22 CCR 51303(a), 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”.

National Committee for Quality Assurance (NCQA) is a non-profit organization committed to evaluating and publicly reporting on the quality of managed care plans.

Network provider means any provider, group of providers, or entity that has a network provider agreement with a MCO, PIHP, or PAHP, or a subcontractor, and receives Medicaid funding directly or indirectly to order, refer or render covered services as a result of the state's contract with an MCO, PIHP, or PAHP. A network provider is not a subcontractor by virtue of the network provider agreement.

Nonrisk contract means a contract between the State and a PIHP or PAHP under which the contractor:

1. **Is not at financial risk for changes in utilization or for costs incurred under the contract that do not exceed the upper payment limits specified in 42 CFR § 447.362; and**
2. **May be reimbursed by the State at the end of the contract period on the basis of the incurred costs, subject to the specified limits.**

Newborn Child means a child born to a Member during her membership or the month prior to her membership.

Non-Medical Transportation means transportation of Members to dental 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.

Operations Period means the period of time under this Contract that commences at the conclusion of the Implementation Period when the Contractor is responsible for the delivery of Covered Services to Members, and DHCS is responsible for payment for such Covered Services.

Other Healthcare Coverage (OHC) means coverage for dental related services or entitlements for which an Eligible Beneficiary is eligible under a private dental plan, any indemnification insurance program, any other State or federal dental 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 dental benefits provided to a Member. This responsibility may result from a dental insurance policy or other contractual agreement or legal obligation, excluding tort liability.

Overpayment means any payment made to a network provider by a MCO, PIHP, or PAHP to which the network provider is not entitled to under Title XIX of the Act or any payment to a MCO, PIHP, or PAHP by a State to which the MCO, PIHP, or PAHP is not entitled to under 42 CFR § 438.2.

P Factor means the percentage of connected calls versus non-connected calls and/or busy signals.

Peer Review means a review by members of the profession regarding the quality of care provided a patient, including documentation of care (dental audit), diagnostic steps used, conclusions reached, treatment rendered, appropriateness of utilization (Utilization Review), and reasonableness of charged claims. The evaluation covers how well all dental personnel perform services and how appropriate the services are to meet the Member's needs.

Phaseout Period means the timeframe beginning with the end of Operations Period or contract extension through the following seven (7) months.

Physician Services means professional services performed by dentists, including surgery, consultation, and home, office, and institutional calls.

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 Care Services means covered services, related to an emergency dental condition that are provided after an enrollee is stabilized in order to maintain the stabilized condition, or, to improve or resolve the enrollee's condition.

Potential Enrollee means a Medi-Cal **beneficiary who is subject to mandatory enrollment or may voluntarily elect to enroll in a given MCO, PIHP, PAHP, PCCM or PCCM entity, but is not yet an enrollee of a specific MCO, PIHP, PAHP, PCCM, or PCCM entity.** ~~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~~.

Prepaid Ambulatory Health Plan (PAHP) means an entity that—

1. **Provides services to enrollees under contract with the State, and on the basis of capitation payments, or other payment arrangements that do not use State plan payment rates.**
2. **Does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and**
3. **Does not have a comprehensive risk contract.**

Prepaid Health Plan (PHP) Program means the Medi-Cal Dental Managed Care PHP program.

Prepaid Inpatient Health Plan (PIHP) means an entity that—

1. **Provides services to enrollees under contract with the State, and on the basis of capitation payments, or other payment arrangements that do not use State plan payment rates.**
2. **Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and,**
3. **Does not have a comprehensive risk contract.**

Preventive Services means dental care designed to prevent dental disease and/or its consequences.

Primary Dental Care means a basic level of dental care usually rendered by general dentists and, in the case of certain children and adolescents, by pediatric dentists. This type of care emphasizes providing a Member's general dental care needs and typically involves ongoing, continuous care as distinguished from the dental care provided by Specialists.

Primary Care means all health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine

physician, obstetrician/gynecologist, pediatrician, or other licensed practitioner as authorized by the State Medicaid program, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them.

Primary Care Case Management means a system under which:

1. **A primary care case manager (PCCM) contracts with the State to furnish case management services (which include the location, coordination and monitoring of primary health care services) to Medicaid beneficiaries; or**
2. **A PCCM entity contracts with the State to provide a defined set of functions**

Primary Care Case Management Entity (PCCM entity) means an organization that provides any of the following functions, in addition to primary care case management services, for the State:

1. **Provision of intensive telephonic or face-to-face case management, including operation of a nurse triage advice line.**
2. **Development of enrollee care plans.**
3. **Execution of contracts with and/or oversight responsibilities for the activities of FFS providers in the FFS program.**
4. **Provision of payments to FFS providers on behalf of the State.**
5. **Provision of Member outreach and education activities.**
6. **Operation of a customer service call center.**
7. **Review of provider claims, utilization and practice patterns to conduct provider profiling and/or practice improvement.**
8. **Implementation of quality improvement activities including administering Member satisfaction surveys or collecting data necessary for performance measurement of providers.**
9. **Coordination with behavioral health systems/providers**
10. **Coordination with long-term services and supports systems/providers**

Primary Care Case Manager (PCCM) means a physician, a physician group practice or, at State option, any of the following:

1. **A physician assistant.**
2. **A nurse practitioner.**
3. **A certified nurse-midwife**

Primary Care Dentist (PCD) means a dentist licensed by and in good standing with the Dental Board of California and is responsible for supervising, coordinating, and providing initial and Primary Dental Care to Members, for initiating referrals, and for maintaining the continuity of dental care for the Member.

Prior Authorization means a formal process requiring a Provider to obtain advance approval to provide specific services or procedures.

Provider means a Primary Care Dentist, dentist, dental group, Subcontractor, Sub-subcontractor, or other individual or entity that renders Covered Services to a Member~~.~~**, that is**

engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the State in which it delivers the services.

Provider Grievance means an oral or written expression of dissatisfaction, including any complaint, dispute, and request for reconsideration or appeal made by a Provider. DHCS considers complaints and appeals the same as a grievance.

Quality Assurance (QA) means a formal set of activities to assure the quality of clinical and non-clinical services provided. Quality Assurance includes quality assessment and Corrective Actions taken to remedy any deficiencies identified through the assessment process. Comprehensive Quality Assurance includes mechanisms to assess and assure the quality of both dental services and administrative and support services.

Quality Improvement System (QIS) means the systematic activities to monitor and evaluate the dental 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/Quality Measures/Performance Measures 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.

Rate Cell means a set of mutually exclusive categories of enrollees that is defined by one or more characteristics for the purpose of determining the capitation rate and making a capitation payment; such characteristics may include age, gender, eligibility category, and region or geographic area. Each enrollee should be categorized in one of the rate cells for each unique set of mutually exclusive benefits under the contract.

Rating Period means a period of 12 months selected by the State for which the actuarially sound capitation rates are developed and documented in the rate certification submitted to CMS as required by 42 CFR § 438.7(a).

Risk Contract means a contract between the State an MCO, PIHP or PAHP under which the contractor—

1. **Assumes risk for the cost of the services covered under the contract; and**
2. **Incurs loss if the cost of furnishing the services exceeds the payments under the contract.**

Rural Health Clinic (RHC) means an entity defined in 22 CCR 51115.5.

Seniors and Persons with Disabilities mean Medi-Cal beneficiaries eligible for benefits through blindness, age or disability, in accordance with 42 USC **§** 1381 et. seq.

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 Location means any location or Facility at which a Member obtains any Covered Services rendered by a Provider under the terms of this Contract.

Specialist means any dentist whose practice is directed at highly specialized dental procedures where certification is either required or encouraged by the dental community. Generally, such dentist would derive their patients from a referring Primary Care Dentist and would not maintain an on-going relationship with the patient beyond the course of treatment required by the referral.

State means the State of California.

Subcontract means a written agreement entered into by the Contractor with any of the following:

A. A provider of dental 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.

Subcontractor means an individual or in many cases a business that signs a contract to perform part or all of the obligations of another's contract. **In addition, the individual or entity that has a contract with Contractor that relates directly or indirectly to the performance of the Contractor's obligations under its contract with the State. A network provider is not a subcontractor by virtue of the network provider agreement with the Contractor.**

State means the Single State agency as specified in 42 CFR § 431.10.

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.

Targeted Low-Income Child means a plan Member whose presumptive eligibility determination for Medi-Cal places them in transitory aid codes 5C or 5D, or whose Medi-Cal eligibility places them in aid codes H1, H2, H3, H4, or H5.

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).

Utilization Review means the process of evaluating the necessity, appropriateness, and efficiency of the use of dental services, procedures and Facilities.

EXHIBIT E, ATTACHMENT 2
DUTIES OF THE STATE

A. Payment for Services

Pursuant to Exhibit B, Budget Detail and Payment, Provision C, Capitation Payment, the DHCS shall pay to the Contractor capitation payments for each eligible Member under this contract. DHCS shall ensure that payments are based on actuarially sound capitation rates as defined in 42 CFR,438.6(c).

B. Dental and Other Reviews

DHCS shall conduct reviews in accordance with the provisions of Welfare and Institutions (W&I) Code sections 14456 and 14457. In accordance with W&I Code section 14556, 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. In an effort to eliminate duplication of auditing efforts, these plan performance reports, audits and reviews may be in lieu of an audit or review conducted by DHCS.

C. Enrollment

DHCS' Medi-Cal managed care system is to improve quality and access to care for Medi-Cal beneficiaries. For the purpose of this contract, the DHCS and the Contractor acknowledge that the Medi-Cal eligibility process and the managed care enrollment system are dynamic and complex programs. DHCS shall cooperatively work with the Contractor to ensure 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 Exhibit E, Attachment 2, Provision D, Enrollment and Disenrollment Processing. The DHCS agrees that to accomplish this goal it is necessary to be reasonably flexible with regard to the enrollment process.

D. Enrollment and Disenrollment Processing

1. DHCS Enrollment Obligations

    a. DHCS shall receive applications for enrollment from its Enrollment Contractor. DHCS 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 Eligible Beneficiaries in the Contractor's plan when selected by the Eligible Beneficiary. The Beneficiary will receive an effective date of plan enrollment that is no later than ninety (90) calendar days from the date that the Medi-Cal Eligibility Data System identifies the Beneficiary as satisfying the enrollment criteria. DHCS shall provide the Contractor a list of Members on a monthly basis and no later than the 10th calendar day of each month.

2. Enrollment Competition

Notwithstanding any provision in this contract or law, the DHCS shall ensure that Eligible Beneficiaries have a choice of competing dental plans in the Geographic Managed Care program. DHCS makes no representations or guarantees relating to the number of Eligible Beneficiaries who may choose to be enrolled in Contractor's plan. DHCS shall not be liable for any lack of Eligible Beneficiary Enrollment in Contractor's plan.

3. Disenrollment Processing

   DHCS, or its Enrollment Contractor, shall review and process requests for disenrollment and notify the Contractor and the Member of its decision.

E. 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 forty-five (45) calendar days of receipt. At the conclusion of the review, DHCS will provide written notification to the Contractor identifying whether the materials are approved or denied. If the materials are denied, DHCS shall provide a written explanation as to why the materials were not approved.

Absent the DHCS' written approval of submitted material, the Contractor may be subject to sanctions for the publication of any unapproved material. This Provision shall not apply to subcontracts or sub-subcontracts subject to DHCS approval in accordance with Exhibit A, Attachment 8, Provider Network, Provision J, Subsection 2.

F. Risk Limitation

Except as provided in Exhibit B, Budget Detail and Payment, Provision J, the DHCS shall ensure that this Contract shall be free of any risk limitation, and the Contractor shall have full financial liability to provide medically necessary dental covered services to its Members.

G. Member Notification

DHCS shall notify Members of their dental care benefits and options available upon termination or expiration of this contract.

Exhibit F

Contractor's Release

Instructions to Contractor:

With final invoice(s) submit one (1) original and one (1) copy. The original must bear the original signature of a person authorized to bind the Contractor. The additional copy may bear photocopied signatures.

Submission of Final Invoice

Pursuant to **contract number** _____ entered into between the 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 minimum of 0% unless otherwise specified in writing of post consumer material, as defined in the Public Contract Code Section 12200, in products, materials, goods, or supplies offered or sold to the State regardless of whether it meets the requirements of Public Contract Code Section 12209. Contractor specifies that printer or duplication cartridges offered or sold to the State comply with the requirements of Section 12156(e).

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 IT TO THE FINAL INVOICE

Contractor's Legal Name (as on contract): _____

Signature of Contractor or Official Designee: _____ Date: _____

Printed Name/Title of Person Signing: _____

Distribution: Accounting (Original) Program

Exhibit G
Health Insurance Portability and Accountability Act (HIPAA) Business Associate Addendum

I. Recitals

A. This Contract (Agreement) has been determined to constitute a business associate relationship under the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (“HIPAA”), the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ('the HITECH Act"), 42 U.S.C. section 17921 et seq., and their implementing privacy and security regulations at 45 CFR Parts 160 and 164 (“the HIPAA regulations”).

B. The Department of Health Care Services (“DHCS”) wishes to disclose to Business Associate certain information pursuant to the terms of this Agreement, some of which may constitute Protected Health Information (“PHI”), including protected health information in electronic media (“ePHI”), under federal law, and personal information ("PI") under state law.

C. As set forth in this Agreement, Contractor, here and after, is the Business Associate of DHCS acting on DHCS' behalf and provides services, arranges, performs or assists in the performance of functions or activities on behalf of DHCS and creates, receives, maintains, transmits, uses or discloses PHI and PI. DHCS and Business Associate are each a party to this Agreement and are collectively referred to as the "parties.”

D. The purpose of this Addendum is to protect the privacy and security of the PHI and PI that may be created, received, maintained, transmitted, used or disclosed pursuant to this Agreement, and to comply with certain standards and requirements of HIPAA, the HITECH Act and the HIPAA regulations, including, but not limited to, the requirement that DHCS must enter into a contract containing specific requirements with Contractor prior to the disclosure of PHI to Contractor, as set forth in 45 CFR Parts 160 and 164 and the HITECH Act, and the Final Omnibus Rule as well as the Alcohol and Drug Abuse patient records confidentiality law 42 CFR Part 2, and any other applicable state or federal law or regulation. 42 CFR section 2.1(b)(2)(B) allows for the disclosure of such records to qualified personnel for the purpose of conducting management or financial audits, or program evaluation. 42 CFR Section 2.53(d) provides that patient identifying information disclosed under this section may be disclosed only back to the program from which it was obtained and used only to carry out an audit or evaluation purpose or to investigate or prosecute criminal or other activities, as authorized by an appropriate court order.

E. The terms used in this Addendum, but not otherwise defined, shall have the same meanings as those terms have in the HIPAA regulations. Any reference to statutory or regulatory language shall be to such language as in effect or as amended.

II. Definitions

A. Breach shall have the meaning given to such term under HIPAA, the HITECH Act, the HIPAA regulations, and the Final Omnibus Rule.

B. Business Associate shall have the meaning given to such term under HIPAA, the HITECH Act, the HIPAA regulations, and the final Omnibus Rule.

C. Covered Entity shall have the meaning given to such term under HIPAA, the HITECH Act, the HIPAA regulations, and Final Omnibus Rule.

D. Electronic Health Record shall have the meaning given to such term in the HITECH Act, including, but not limited to, 42 U.S.C Section 17921 and implementing regulations.

E. Electronic Protected Health Information (ePHI) means individually identifiable health information transmitted by electronic media or maintained in electronic media, including but not limited to electronic media as set forth under 45 CFR section 160.103.

F. Individually Identifiable Health Information means health information, including demographic information collected from an individual, that is created or received by a health care provider, health plan, employer or health care clearinghouse, and relates to the past, present or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, that identifies the individual or where there is a reasonable basis to believe the information can be used to identify the individual, as set forth under 45 CFR section 160.103.

G. Privacy Rule shall mean the HIPAA Regulation that is found at 45 CFR Parts 160 and 164.

H. Personal Information shall have the meaning given to such term in California Civil Code section 1798.29.

I. Protected Health Information means individually identifiable health information that is transmitted by electronic media, maintained in electronic media, or is transmitted or maintained in any other form or medium, as set forth under 45 CFR section 160.103.

J. Required by law, as set forth under 45 CFR section 164.103, means a mandate contained in law that compels an entity to make a use or disclosure of PHI that is enforceable in a court of law. This includes, but is not limited to, court orders and court-ordered warrants, subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or an administrative body authorized to require the production of information, and a civil or an authorized investigative demand. It also includes Medicare conditions of participation with respect to health care providers participating in the program, and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits.

K. Secretary means the Secretary of the U.S. Department of Health and Human Services ("HHS") or the Secretary's designee.

L. Security Incident means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of PHI or PI, or confidential data that is essential to the ongoing operation of the Business Associate’s organization and intended for internal use; or interference with system operations in an information system.

M. Security Rule shall mean the HIPAA regulation that is found at 45 CFR Parts 160 and 164.

N. Unsecured PHI shall have the meaning given to such term under the HITECH Act, 42 U.S.C. section 17932(h), any guidance issued pursuant to such Act, and the HIPAA regulations.

III. Terms of Agreement

A. Permitted Uses and Disclosures of PHI by Business Associate

Permitted Uses and Disclosures. Except as otherwise indicated in this Addendum, Business Associate may use or disclose PHI only to perform functions, activities or services specified in this Agreement, for, or on behalf of DHCS, provided that such use or disclosure would not violate the HIPAA regulations, if done by DHCS. Any such use or disclosure must, to the extent practicable, be limited to the limited data set, as defined in 45 CFR section 164.514(e)(2), or, if needed, to the minimum necessary to accomplish

the intended purpose of such use or disclosure, in compliance with the HITECH Act and any guidance issued pursuant to such Act, the HIPAA regulations, the Final Omnibus Rule and 42 CFR Part 2.

1. ***Specific Use and Disclosure Provisions***. Except as otherwise indicated in this Addendum, Business Associate may:

    a. ***Use and disclose for management and administration***. Use and disclose PHI for the proper management and administration of the Business Associate provided that such disclosures are required by law, or the Business Associate 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 Business Associate of any instances of which it is aware that the confidentiality of the information has been breached.

    b. ***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 Business Associate on behalf of DHCS with PHI received by the Business Associate in its capacity as the Business Associate of another covered entity, to permit data analyses that relate to the health care operations of DHCS.

B. Prohibited Uses and Disclosures

1. Business Associate shall not disclose PHI about an individual to a health plan for payment or health care operations purposes if the PHI pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full and the individual requests such restriction, in accordance with 42 U.S.C. section 17935(a) and 45 CFR section 164.522(a).

2. Business Associate shall not directly or indirectly receive remuneration in exchange for PHI, except with the prior written consent of DHCS and as permitted by 42 U.S.C. section 17935(d)(2).

C. Responsibilities of Business Associate

Business Associate agrees:

1. ***Nondisclosure***. Not to use or disclose Protected Health Information (PHI) other than as permitted or required by this Agreement or as required by law.

2. ***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, uses or transmits on behalf of DHCS, in compliance with 45 CFR sections 164.308, 164.310 and 164.312, and to prevent use or disclosure of PHI other than as provided for by this Agreement. Business Associate shall implement reasonable and appropriate policies and procedures to comply with the standards, implementation specifications and other requirements of 45 CFR section 164, subpart C, in compliance with 45 CFR section 164.316. Business Associate shall develop and maintain a written information privacy and security program that includes administrative, technical and physical safeguards appropriate to the size and complexity of the Business Associate's operations and the nature and scope of its activities, and which incorporates the requirements of section 3, Security, below. Business Associate will provide DHCS with its current and updated policies.

3. ***Security***. To take any and all steps necessary to ensure the continuous security of all computerized data systems containing PHI and/or PI, and to protect paper documents containing PHI and/or PI. These steps shall include, at a minimum:

   a. Complying with all of the data system security precautions listed in Attachment A, the Business Associate Data Security Requirements;

   b. Achieving and maintaining compliance with the HIPAA Security Rule (45 CFR Parts 160 and 164), as necessary in conducting operations on behalf of DHCS under this Agreement;

   c. Providing a level and scope of security that is at least comparable to the level and scope of security established by the Office of Management and Budget in OMB Circular No. A-130, Appendix III - Security of Federal Automated Information Systems, which sets forth guidelines for automated information systems in Federal agencies; and

   d. In case of a conflict between any of the security standards contained in any of these enumerated sources of security standards, the most stringent shall apply. The most stringent means that safeguard which provides the highest level of protection to PHI from unauthorized disclosure. Further, Business Associate must comply with changes to these standards that occur after the effective date of this Agreement.

   Business Associate shall designate a Security Officer to oversee its data security program who shall be responsible for carrying out the requirements of this section and for communicating on security matters with DHCS.

D. ***Mitigation of Harmful Effects***. To mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate or its subcontractors in violation of the requirements of this Addendum.

E. ***Business Associate's Agents and Subcontractors***.

1. To enter into written agreements with any agents, including subcontractors and vendors, to whom Business Associate provides PHI or PI received from or created or received by Business Associate on behalf of DHCS, that impose the same restrictions and conditions on such agents, subcontractors and vendors that apply to Business Associate with respect to such PHI and PI under this Addendum, and that comply with all applicable provisions of HIPAA, the HITECH Act the HIPAA regulations, and the Final Omnibus Rule, including the requirement that any agents, subcontractors or vendors implement reasonable and appropriate administrative, physical, and technical safeguards to protect such PHI and PI. Business associates are directly liable under the HIPAA Rules and subject to civil and, in some cases, criminal penalties for making uses and disclosures of protected health information that are not authorized by its contract or required by law. A business associate also is directly liable and subject to civil penalties for failing to safeguard electronic protected health information in accordance with the HIPAA Security Rule. A "business associate" also is a subcontractor that creates, receives, maintains, or transmits protected health information on behalf of another business associate. Business Associate shall incorporate, when applicable, the relevant provisions of this Addendum into each subcontract or subaward to such agents, subcontractors and vendors, including the requirement that any security incidents or breaches of unsecured PHI or PI be reported to Business Associate.

2. In accordance with 45 CFR section 164.504(e)(1)(ii), upon Business Associate's knowledge of a material breach or violation by its subcontractor of the agreement between Business Associate and the subcontractor, Business Associate shall:

a. Provide an opportunity for the subcontractor to cure the breach or end the violation and terminate the agreement if the subcontractor does not cure the breach or end the violation within the time specified by DHCS; or

b. Immediately terminate the agreement if the subcontractor has breached a material term of the agreement and cure is not possible.

F. ***Availability of Information to DHCS and Individuals****.* To provide access and information:

1. To provide access as DHCS may require, and in the time and manner designated by DHCS (upon reasonable notice and during Business Associate's normal business hours) to PHI in a Designated Record Set, to DHCS (or, as directed by DHCS), to an Individual, in accordance with 45 CFR section 164.524. Designated Record Set means the group of records maintained for DHCS that includes medical, dental and billing records about individuals; enrollment, payment, claims adjudication, and case or medical management systems maintained for DHCS health plans; or those records used to make decisions about individuals on behalf of DHCS. Business Associate shall use the forms and processes developed by DHCS for this purpose and shall respond to requests for access to records transmitted by DHCS within fifteen (15) calendar days of receipt of the request by producing the records or verifying that there are none.

2. If Business Associate maintains an Electronic Health Record with PHI, and an individual requests a copy of such information in an electronic format, Business Associate shall provide such information in an electronic format to enable DHCS to fulfill its obligations under the HITECH Act, including but not limited to, 42 U.S.C. section 17935(e).

3. If Business Associate receives data from DHCS that was provided to DHCS by the Social Security Administration, upon request by DHCS, Business Associate shall provide DHCS with a list of all employees, contractors and agents who have access to the Social Security data, including employees, contractors and agents of its subcontractors and agents.

G. ***Amendment of PHI.*** To make any amendment(s) to PHI that DHCS directs or agrees to pursuant to 45 CFR section 164.526, in the time and manner designated by DHCS.

H. ***Internal Practices****.* To make Business Associate's internal practices, books and records relating to the use and disclosure of PHI received from DHCS, or created or received by Business Associate on behalf of DHCS, available to DHCS or to the Secretary of the U.S. Department of Health and Human Services in a time and manner designated by DHCS or by the Secretary, for purposes of determining DHCS' compliance with the HIPAA regulations. If any information needed for this purpose is in the exclusive possession of any other entity or person and the other entity or person fails or refuses to furnish the information to Business Associate, Business Associate shall so certify to DHCS and shall set forth the efforts it made to obtain the information.

I. ***Documentation of Disclosures***. To document and make available to DHCS or (at the direction of DHCS) to an Individual such disclosures of PHI, and information related to such disclosures, necessary to respond to a proper request by the subject Individual for an accounting of disclosures of PHI, in accordance with the HITECH Act and its implementing regulations, including but not limited to 45 CFR section 164.528 and 42 U.S.C. section 17935(c). If Business Associate maintains electronic health records for DHCS as of January 1, 2009, Business Associate must provide an accounting of disclosures, including those disclosures for treatment, payment or health care operations, effective with disclosures on or after January 1, 2014. If Business Associate acquires electronic health records for DHCS after January 1, 2009, Business Associate must provide an accounting of disclosures, including those disclosures for treatment, payment or health care operations, effective with disclosures on or after the date the electronic health record is acquired, or on or after January 1, 2011, whichever date is later. The electronic accounting of disclosures shall be for disclosures during the three years prior to the request for an accounting.

J. ***Breaches and Security Incidents.*** During the term of this Agreement, Business Associate agrees to implement reasonable systems for the discovery and prompt reporting of any breach or security incident, and to take the following steps:

1. ***Notice to DHCS.*** (1) To notify DHCS **immediately** upon the discovery of a suspected security incident that involves data provided to DHCS by the Social Security Administration. This notification will be **by telephone call plus email or fax** upon the discovery of the breach. (2) To notify DHCS **within 24 hours by email or fax** of the discovery of unsecured PHI or PI in electronic media or in any other media if the PHI or PI was, or is reasonably believed to have been, accessed or acquired by an unauthorized person, any suspected security incident, intrusion or unauthorized access, use or disclosure of PHI or PI in violation of this Agreement and this Addendum, or potential loss of confidential data affecting this Agreement. A breach shall be treated as discovered by Business Associate as of the first day on which the breach is known, or by exercising reasonable diligence would have been known, to any person (other than the person committing the breach) who is an employee, officer or other agent of Business Associate.

   Notice shall be provided to the DHCS Program Contract Manager, 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 data provided to DHCS by the Social Security Administration, notice shall be provided by calling the DHCS EITS Service Desk. Notice shall be made using the "DHCS Privacy Incident Report" form, including all information known at the time. Business Associate shall use the most current version of this form, which is posted on the DHCS Privacy Office website (www.dhcs.ca.gov, then select "Privacy" in the left column and then "Business Use" near the middle of the page) or use this link:
   http://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/DHCSBusinessAssociatesOnly.aspx

   Upon discovery of a breach or suspected security incident, intrusion or unauthorized access, use or disclosure of PHI or PI, Business Associate 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 and Investigation Report.*** To immediately investigate such security incident, breach, or unauthorized access, use or disclosure of PHI or PI. If the initial report did not include all of the requested information marked with an asterisk, then within 72 hours of the discovery, Business Associate shall submit an updated "DHCS Privacy Incident Report" containing the information marked with an asterisk and all other applicable information listed on the form, to the extent known at that time, to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer:

3. ***Complete Report.*** To provide a complete report of the investigation to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer within ten (10) working days of the discovery of the breach or unauthorized use or disclosure. If all of the required information was not included in either the initial report, or the Investigation Report, then a separate Complete Report must be submitted. The report shall be submitted on the "DHCS Privacy Incident Report" form and shall include an assessment of all known factors relevant to a determination of whether a breach occurred under applicable provisions of HIPAA, the HITECH Act, the HIPAA regulations and/or state law. The report shall also include a full, detailed corrective action plan, including information on measures that were taken to halt and/or contain the improper use or disclosure. If DHCS requests information in addition to that listed on the "DHCS Privacy Incident Report" form, Business Associate shall make reasonable efforts to provide DHCS with such information. If necessary, a Supplemental Report may be used to submit revised or additional information after the completed report is submitted, by submitting the revised or additional information on an updated "DHCS Privacy Incident Report" form. DHCS will review and approve or disapprove the determination of whether a breach occurred, is reportable to the appropriate entities, if individual notifications are required, and the corrective action plan.

4. ***Notification of Individuals.*** If the cause of a breach of PHI or PI is attributable to Business Associate or its subcontractors, agents or vendors, Business Associate shall notify individuals of the breach or unauthorized use or disclosure when notification is required under state or federal law and shall pay any costs of such notifications, as well as any costs associated with the breach. The notifications shall comply with the requirements set forth in 42 U.S.C. section 17932 and its implementing regulations, including, but not limited to, the requirement that the notifications be made without unreasonable delay and in no event later than 60 calendar days. The DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer shall approve the time, manner and content of any such notifications and their review and approval must be obtained before the notifications are made.

5. ***Responsibility for Reporting of Breaches.*** If the cause of a breach of PHI or PI is attributable to Business Associate or its agents, subcontractors or vendors, Business Associate is responsible for all required reporting of the breach as specified in 42 U.S.C. section 17932 and its implementing regulations, including notification to media outlets and to the Secretary. If a breach of unsecured PHI involves more than 500 residents of the State of California or its jurisdiction, Business Associate shall notify the Secretary of the breach immediately upon discovery of the breach. If Business Associate has reason to believe that duplicate reporting of the same breach or incident may occur because its subcontractors, agents or vendors may report the breach or incident to DHCS in addition to Business Associate, Business Associate shall notify DHCS, and DHCS and Business Associate may take appropriate action to prevent duplicate reporting. The breach reporting requirements of this paragraph are in addition to the reporting requirements set forth in subsection 1, above.

6. ***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 Addendum or the Agreement to which it is incorporated.

DHCS Program Contract Manager	DHCS Privacy Officer	DHCS Information Security Officer
See the Scope of Work exhibit for Program Contract Manager information	Privacy Officer c/o: Office of HIPAA Compliance Department of Health Care Services P.O. Box 997413, MS 4722 Sacramento, CA 95899-7413 Email: privacyofficer@dhcs.ca.gov Telephone: (916) 445-4646 Fax: (916) 440-7680	Information Security Officer DHCS Information Security Office P.O. Box 997413, MS 6400 Sacramento, CA 95899-7413 Email: iso@dhcs.ca.gov Fax: (916) 440-5537 Telephone: EITS Service Desk (916) 440-7000 or (800) 579-0874

K. ***Termination of Agreement.*** In accordance with Section 13404(b) of the HITECH Act and to the extent required by the HIPAA regulations, if Business Associate knows of a material breach or violation by DHCS of this Addendum, it shall take the following steps:

1. Provide an opportunity for DHCS to cure the breach or end the violation and terminate the Agreement if DHCS does not cure the breach or end the violation within the time specified by Business Associate; or
2. Immediately terminate the Agreement if DHCS has breached a material term of the Addendum and cure is not possible.

L. ***Due Diligence.*** Business Associate shall exercise due diligence and shall take reasonable steps to ensure that it remains in compliance with this Addendum and is in compliance with applicable provisions of HIPAA, the HITECH Act and the HIPAA regulations, and that its agents, subcontractors and vendors are in compliance with their obligations as required by this Addendum.

M. ***Sanctions and/or Penalties***. Business Associate understands that a failure to comply with the provisions of HIPAA, the HITECH Act and the HIPAA regulations that are applicable to Business Associate may result in the imposition of sanctions and/or penalties on Business Associate under HIPAA, the HITECH Act and the HIPAA regulations.

IV. Obligations of DHCS

DHCS agrees to:

A. ***Notice of Privacy Practices***. Provide Business Associate with the Notice of Privacy Practices that DHCS produces in accordance with 45 CFR section 164.520, as well as any changes to such notice. Visit the DHCS Privacy Office to view the most current Notice of Privacy Practices at: http://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/default.aspx or the DHCS website at www.dhcs.ca.gov (select "Privacy in the left column and "Notice of Privacy Practices" on the right side of the page).

B. ***Permission by Individuals for Use and Disclosure of PHI***. Provide the Business Associate with any changes in, or revocation of, permission by an Individual to use or disclose PHI, if such changes affect the Business Associate's permitted or required uses and disclosures.

C. ***Notification of Restrictions.*** Notify the Business Associate of any restriction to the use or disclosure of PHI that DHCS has agreed to in accordance with 45 CFR section 164.522, to the extent that such restriction may affect the Business Associate's use or disclosure of PHI.

D. ***Requests Conflicting with HIPAA Rules.*** Not request the Business Associate to use or disclose PHI in any manner that would not be permissible under the HIPAA regulations if done by DHCS.

V. Audits, Inspection and Enforcement

A. From time to time, DHCS may inspect the facilities, systems, books and records of Business Associate to monitor compliance with this Agreement and this Addendum. Business Associate shall promptly remedy any violation of any provision of this Addendum and shall certify the same to the DHCS Privacy Officer in writing. The fact that DHCS inspects, or fails to inspect, or has the right to inspect, Business Associate's facilities, systems and procedures does not relieve Business Associate of its responsibility to comply with this Addendum, nor does DHCS':

1. Failure to detect or

2. Detection, but failure to notify Business Associate or require Business Associate's remediation of any unsatisfactory practices constitute acceptance of such practice or a waiver of DHCS' enforcement rights under this Agreement and this Addendum.

B. If Business Associate is the subject of an audit, compliance review, or complaint investigation by the Secretary or the Office of Civil Rights, U.S. Department of Health and Human Services, that is related to the performance of its obligations pursuant to this HIPAA Business Associate Addendum, Business Associate shall notify DHCS and provide DHCS with a copy of any PHI or PI that Business Associate provides to the Secretary or the Office of Civil Rights concurrently with providing such PHI or PI to the Secretary. Business Associate is responsible for any civil penalties assessed due to an audit or investigation of Business Associate, in accordance with 42 U.S.C. section 17934(c).

VI. Termination

A. ***Term.*** The Term of this Addendum shall commence as of the effective date of this Addendum and shall extend beyond the termination of the contract and shall terminate when all the PHI provided by DHCS to Business Associate, or created or received by Business Associate on behalf of DHCS, is destroyed or returned to DHCS, in accordance with 45 CFR 164.504(e)(2)(ii)(I).

B. ***Termination for Cause.*** In accordance with 45 CFR section 164.504(e)(1)(ii), upon DHCS' knowledge of a material breach or violation of this Addendum by Business Associate, DHCS shall:

1. Provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Agreement if Business Associate does not cure the breach or end the violation within the time specified by DHCS; or

2. Immediately terminate this Agreement if Business Associate has breached a material term of this Addendum and cure is not possible.

C. ***Judicial or Administrative Proceedings.*** Business Associate will notify DHCS if it is named as a defendant in a criminal proceeding for a violation of HIPAA. DHCS may terminate this Agreement if Business Associate is found guilty of a criminal violation of HIPAA. DHCS may terminate this Agreement if a finding or stipulation that the Business Associate has violated any standard or requirement of HIPAA, or other security or privacy laws is made in any administrative or civil proceeding in which the Business Associate is a party or has been joined.

D. ***Effect of Termination.*** Upon termination or expiration of this Agreement for any reason, Business Associate shall return or destroy all PHI received from DHCS (or created or received by Business Associate on behalf of DHCS) that Business Associate still maintains in any form, and shall retain no copies of such PHI. If return or destruction is not feasible, Business Associate shall notify DHCS of the conditions that make the return or destruction infeasible, and DHCS and Business Associate shall determine the terms and conditions under which Business Associate may retain the PHI. Business Associate shall continue to extend the protections of this Addendum to such PHI, and shall limit further use of such PHI to those purposes that make the return or destruction of such PHI infeasible. This provision shall apply to PHI that is in the possession of subcontractors or agents of Business Associate.

VII. Miscellaneous Provisions

A. ***Disclaimer.*** DHCS makes no warranty or representation that compliance by Business Associate with this Addendum, HIPAA or the HIPAA regulations will be adequate or satisfactory for Business Associate's own purposes or that any information in Business Associate's possession or control, or transmitted or received by Business Associate, is or will be secure from unauthorized use or disclosure. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI.

B. ***Amendment.*** The parties acknowledge that federal and state laws relating to electronic data security and privacy are rapidly evolving and that amendment of this Addendum 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 HITECH Act, the HIPAA regulations and other applicable laws relating to the security or privacy of PHI. Upon DHCS' request, Business Associate agrees to promptly enter into negotiations with DHCS concerning an amendment to this Addendum embodying written assurances consistent with the standards and requirements of HIPAA, the HITECH Act, the HIPAA regulations or other applicable laws. DHCS may terminate this Agreement upon thirty (30) days written notice in the event:

1. Business Associate does not promptly enter into negotiations to amend this Addendum when requested by DHCS pursuant to this Section; or

2. Business Associate 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 and the HIPAA regulations.

C. ***Assistance in Litigation or Administrative Proceedings.*** Business Associate shall make itself and any subcontractors, employees or agents assisting Business Associate in the performance of its obligations under this Agreement, 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, which involves inactions or actions by the Business Associate, except where Business Associate or its subcontractor, employee or agent is a named adverse party.

D. ***No Third-Party Beneficiaries***. Nothing express or implied in the terms and conditions of this Addendum is intended to confer, nor shall anything herein confer, upon any person other than DHCS or Business Associate and their respective successors or assignees, any rights, remedies, obligations or liabilities whatsoever.

E. ***Interpretation***. The terms and conditions in this Addendum shall be interpreted as broadly as necessary to implement and comply with HIPAA, the HITECH Act, the HIPAA regulations and applicable state laws. The parties agree that any ambiguity in the terms and conditions of this Addendum shall be resolved in favor of a meaning that complies and is consistent with HIPAA, the HITECH Act and the HIPAA regulations.

F. ***Regulatory References***. A reference in the terms and conditions of this Addendum to a section in the HIPAA regulations means the section as in effect or as amended.

G. ***Survival.*** The respective rights and obligations of Business Associate under Section VI.D of this Addendum shall survive the termination or expiration of this Agreement.

H. ***No Waiver of Obligations***. No change, waiver or discharge of any liability or obligation hereunder on any one or more occasions shall be deemed a waiver of performance of any continuing or other obligation, or shall prohibit enforcement of any obligation, on any other occasion.

Attachment A
Business Associate Data Security Requirements

I. Personnel Controls

A. ***Employee Training.*** All workforce members who assist in the performance of functions or activities on behalf of DHCS, or access or disclose DHCS PHI or PI must complete information privacy and security training, at least annually, at Business Associate's expense. Each workforce member who receives information privacy and security training must sign a certification, indicating the member's name and the date on which the training was completed. These certifications must be retained for a period of six (6) years following contract termination.

B. ***Employee Discipline.*** Appropriate sanctions must be applied against workforce members who fail to comply with privacy policies and procedures or any provisions of these requirements, including termination of employment where appropriate.

C. ***Confidentiality Statement.*** All persons that will be working with DHCS PHI or PI must sign a confidentiality statement that includes, 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 or PI. The statement must be renewed annually. The Contractor shall retain each person's written confidentiality statement for DHCS inspection for a period of six (6) years following contract termination.

D. ***Background Check.*** Before a member of the workforce may access DHCS PHI or PI, a thorough background check of that worker must be conducted, with evaluation of the results to assure that there is no indication that the worker may present a risk to the security or integrity of confidential data or a risk for theft or misuse of confidential data. The Contractor shall retain each workforce member's background check documentation for a period of three (3) years following contract termination.

II. Technical Security Controls

A. ***Workstation/Laptop encryption.*** All workstations and laptops that process and/or store DHCS PHI or PI must be encrypted using a FIPS 140-2 certified algorithm which is 128bit or higher, such as Advanced Encryption Standard (AES). The encryption solution must be full disk unless approved by the DHCS Information Security Office.

B. ***Server Security.*** Servers containing unencrypted DHCS PHI or PI must have sufficient administrative, physical, and technical controls in place to protect that data, based upon a risk assessment/system security review.

C. ***Minimum Necessary.*** Only the minimum necessary amount of DHCS PHI or PI required to perform necessary business functions may be copied, downloaded, or exported.

D. ***Removable media devices.*** All electronic files that contain DHCS PHI or PI data must be encrypted when stored on any removable media or portable device (i.e. USB thumb drives, floppies, CD/DVD, smartphones, backup tapes etc.). Encryption must be a FIPS 140-2 certified algorithm which is 128bit or higher, such as AES.

E. ***Antivirus software.*** All workstations, laptops and other systems that process and/or store DHCS PHI or PI must install and actively use comprehensive anti-virus software solution with automatic updates scheduled at least daily.

F. ***Patch Management.*** All workstations, laptops and other systems that process and/or store DHCS PHI or PI must have critical security patches applied, with system reboot if necessary. There must be a documented patch management process which determines installation timeframe based on risk assessment and vendor recommendations. At a maximum, all applicable patches must be installed within 30 days of vendor release.

G. ***User IDs and Password Controls.*** All users must be issued a unique user name for accessing DHCS PHI or PI. Username must be promptly disabled, deleted, or the password changed upon the transfer or termination of an employee with knowledge of the password, at maximum within 24 hours. Passwords are not to be shared. Passwords must be at least eight characters and must be a non-dictionary word. Passwords must not be stored in readable format on the computer. Passwords must be changed every 90 days, preferably every 60 days. Passwords must be changed if revealed or compromised. Passwords must be composed of characters from at least three of the following four groups from the standard keyboard:

- Upper case letters (A-Z)
- Lower case letters (a-z)
- Arabic numerals (0-9)
- Non-alphanumeric characters (punctuation symbols)

H. ***Data Destruction.*** When no longer needed, all DHCS PHI or PI must be cleared, purged, or destroyed consistent with NIST Special Publication 800-88, Guidelines for Media Sanitization such that the PHI or PI cannot be retrieved.

I. ***System Timeout.*** The system providing access to DHCS PHI or PI must provide an automatic timeout, requiring re-authentication of the user session after no more than 20 minutes of inactivity.

J. ***Warning Banners.*** All systems providing access to DHCS PHI or PI must display a warning banner stating that data is confidential, systems are logged, and system use is for business purposes only by authorized users. User must be directed to log off the system if they do not agree with these requirements.

K. ***System Logging*****.** The system must maintain an automated audit trail which can identify the user or system process which initiates a request for DHCS PHI or PI, or which alters DHCS PHI or PI. The audit trail must be date and time stamped, must log both successful and failed accesses, must be read only, and must be restricted to authorized users. If DHCS PHI or PI is stored in a database, database logging functionality must be enabled. Audit trail data must be archived for at least 3 years after occurrence.

L. ***Access Controls.*** The system providing access to DHCS PHI or PI must use role based access controls for all user authentications, enforcing the principle of least privilege.

M. ***Transmission encryption.*** All data transmissions of DHCS PHI or PI outside the secure internal network must be encrypted using a FIPS 140-2 certified algorithm which is 128bit or higher, such as AES. Encryption can be end to end at the network level, or the data files containing PHI can be encrypted. This requirement pertains to any type of PHI or PI in motion such as website access, file transfer, and E-Mail.

N. ***Intrusion Detection***. All systems involved in accessing, holding, transporting, and protecting DHCS PHI or PI that are accessible via the Internet must be protected by a comprehensive intrusion detection and prevention solution.

III. Audit Controls

A. ***System Security Review.*** All systems processing and/or storing DHCS PHI or PI must have at least an annual system risk assessment/security review which provides assurance that administrative, physical, and technical controls are functioning effectively and providing adequate levels of protection. Reviews should include vulnerability scanning tools.

B. ***Log Reviews.*** All systems processing and/or storing DHCS PHI or PI must have a routine procedure in place to review system logs for unauthorized access.

C. ***Change Control.*** All systems processing and/or storing DHCS PHI or PI must have a documented change control procedure that ensures separation of duties and protects the confidentiality, integrity and availability of data.

IV. 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 or PI in the event of an emergency. Emergency means any circumstance or situation that causes normal computer operations to become unavailable for use in performing the work required under this Agreement for more than 24 hours.

B. ***Data Backup Plan.*** Contractor must have established documented procedures to backup DHCS PHI to maintain retrievable exact copies of DHCS PHI or PI. The plan must include a regular schedule for making backups, storing backups offsite, an inventory of backup media, and an estimate of the amount of time needed to restore DHCS PHI or PI should it be lost. At a minimum, the schedule must be a weekly full backup and monthly offsite storage of DHCS data.

V. Paper Document Controls

A. ***Supervision of Data.*** DHCS PHI or PI 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. DHCS PHI or PI 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 or PI is contained shall be escorted and DHCS PHI or PI shall be kept out of sight while visitors are in the area.

C. ***Confidential Destruction.*** DHCS PHI or PI must be disposed of through confidential means, such as cross cut shredding and pulverizing.

D. ***Removal of Data.*** DHCS PHI or PI must not be removed from the premises of the Contractor except with express written permission of DHCS.

E. ***Faxing.*** Faxes containing DHCS PHI or PI 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 the fax.

F. ***Mailing.*** Mailings of DHCS PHI or PI shall be sealed and secured from damage or inappropriate viewing of PHI or PI to the extent possible. Mailings which include 500 or more individually identifiable records of DHCS PHI or PI in a single package shall be sent using a tracked mailing method which includes verification of delivery and receipt, unless the prior written permission of DHCS to use another method is obtained.

Exhibit H
Information Confidentiality and Security Requirements

1. **Definitions**. For purposes of this Exhibit, the following definitions shall apply:

   A. **Public Information:** Information that is not exempt from disclosure under the provisions of the California Public Records Act (Government Code sections 6250-6265) or other applicable state or federal laws.

   B. **Confidential Information:** Information that is exempt from disclosure under the provisions of the California Public Records Act (Government Code sections 6250-6265) or other applicable state or federal laws.

   C. **Sensitive Information:** Information that requires special precautions to protect from unauthorized use, access, disclosure, modification, loss, or deletion. Sensitive Information may be either Public Information or Confidential Information. It is information that requires a higher than normal assurance of accuracy and completeness. Thus, the key factor for Sensitive Information is that of integrity. Typically, Sensitive Information includes records of agency financial transactions and regulatory actions.

   D. **Personal Information:** Information that identifies or describes an individual, including, but not limited to, their name, social security number, physical description, home address, home telephone number, education, financial matters, and medical or employment history. **It is DHCS' policy to consider all information about individuals private unless such information is determined to be a public record.** This information must be protected from inappropriate access, use, or disclosure and must be made accessible to data subjects upon request. Personal Information includes the following:

      Notice-triggering Personal Information: Specific items of personal information (name plus Social Security number, driver license/California identification card number, or financial account number) that may trigger a requirement to notify individuals if it is acquired by an unauthorized person. 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. See Civil Code sections 1798.29 and 1798.82.

2. **Nondisclosure**. The Contractor and its employees, agents, or subcontractors shall protect from unauthorized disclosure any Personal Information, Sensitive Information, or Confidential Information (hereinafter identified as PSCI).

3. The Contractor and its employees, agents, or subcontractors shall not use any PSCI for any purpose other than carrying out the Contractor's obligations under this Agreement.

4. The Contractor and its employees, agents, or subcontractors shall promptly transmit to the DHCS Program Contract Manager all requests for disclosure of any PSCI not emanating from the person who is the subject of PSCI.

5. The Contractor shall not disclose, except as otherwise specifically permitted by this Agreement or authorized by the person who is the subject of PSCI, any PSCI to anyone other than DHCS without prior written authorization from the DHCS Program Contract Manager, except if disclosure is required by State or Federal law.

6. The Contractor shall observe the following requirements:

A. Safeguards. The Contractor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PSCI, including electronic PSCI that it creates, receives, maintains, uses, or transmits on behalf of DHCS. Contractor shall develop and maintain a 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, Including at a minimum the following safeguards:

1) Personnel Controls

a. ***Employee Training.*** All workforce members who assist in the performance of functions or activities on behalf of DHCS, or access or disclose DHCS PSCI, must complete information privacy and security training, at least annually, at Business Associate's expense. Each workforce member who receives information privacy and security training must sign a certification, indicating the member's name and the date on which the training was completed. These certifications must be retained for a period of six (6) years following contract termination.

b. ***Employee Discipline.*** Appropriate sanctions must be applied against workforce members who fail to comply with privacy policies and procedures or any provisions of these requirements, including termination of employment where appropriate.

c. ***Confidentiality Statement.*** All persons that will be working with DHCS PHI or PI must sign a confidentiality statement that includes, 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 or PI. The statement must be renewed annually. The Contractor shall retain each person's written confidentiality statement for DHCS inspection for a period of six (6) years following contract termination.

d. ***Background Check.*** Before a member of the workforce may access DHCS PHI or PI, a thorough background check of that worker must be conducted, with evaluation of the results to assure that there is no indication that the worker may present a risk to the security or integrity of confidential data or a risk for theft or misuse of confidential data. The Contractor shall retain each workforce member's background check documentation for a period of three (3) years following contract termination.

2) Technical Security Controls

a. ***Workstation/Laptop encryption.*** All workstations and laptops that process and/or store DHCS PHI or PI must be encrypted using a FIPS 140-2 certified algorithm which is 128bit or higher, such as Advanced Encryption Standard (AES). The encryption solution must be full disk unless approved by the DHCS Information Security Office.

b. ***Server Security.*** Servers containing unencrypted DHCS PHI or PI must have sufficient administrative, physical, and technical controls in place to protect that data, based upon a risk assessment/system security review.

c. ***Minimum Necessary.*** Only the minimum necessary amount of DHCS PHI or PI required to perform necessary business functions may be copied, downloaded, or exported.

d. ***Removable media devices.*** All electronic files that contain DHCS PHI or PI data must be encrypted when stored on any removable media or portable device (i.e. USB thumb drives, floppies, CD/DVD, Blackberry, backup tapes etc.). Encryption must be a FIPS 140-2 certified algorithm which is 128bit or higher, such as AES.

e. ***Antivirus software.*** All workstations, laptops and other systems that process and/or store DHCS PHI or PI must install and actively use comprehensive anti-virus software solution with automatic updates scheduled at least daily.

f. ***Patch Management.*** All workstations, laptops and other systems that process and/or store DHCS PHI or PI must have critical security patches applied, with system reboot if necessary. There must be a documented patch management process which determines installation timeframe based on risk assessment and vendor recommendations. At a maximum, all applicable patches must be installed within 30 days of vendor release.

g. ***User IDs and Password Controls.*** All users must be issued a unique user name for accessing DHCS PHI or PI. Username must be promptly disabled, deleted, or the password changed upon the transfer or termination of an employee with knowledge of the password, at maximum within 24 hours. Passwords are not to be shared. Passwords must be at least eight characters and must be a non-dictionary word. Passwords must not be stored in readable format on the computer. Passwords must be changed every 90 days, preferably every 60 days. Passwords must be changed if revealed or compromised. Passwords must be composed of characters from at least three of the following four groups from the standard keyboard:

   - Upper case letters (A-Z)
   - Lower case letters (a-z)
   - Arabic numerals (0-9)
   - Non-alphanumeric characters (punctuation symbols)

h. ***Data Destruction.*** When no longer needed, all DHCS PHI or PI must be wiped using the Gutmann or US Department of Defense (DoD) 5220.22-M (7 Pass) standard, or by degaussing. Media may also be physically destroyed in accordance with NIST Special Publication 800-88. Other methods require prior written permission of the DHCS Information Security Office.

i. ***System Timeout.*** The system providing access to DHCS PHI or PI must provide an automatic timeout, requiring re-authentication of the user session after no more than 20 minutes of inactivity.

j. ***Warning Banners.*** All systems providing access to DHCS PHI or PI must display a warning banner stating that data is confidential, systems are logged, and system use is for business purposes only by authorized users. User must be directed to log off the system if they do not agree with these requirements.

k. ***System Logging.*** The system must maintain an automated audit trail which can identify the user or system process which initiates a request for DHCS PHI or PI, or which alters DHCS PHI or PI. The audit trail must be date and time stamped, must log both successful

and failed accesses, must be read only, and must be restricted to authorized users. If DHCS PHI or PI is stored in a database, database logging functionality must be enabled. Audit trail data must be archived for at least 3 years after occurrence.

l. ***Access Controls.*** The system providing access to DHCS PHI or PI must use role based access controls for all user authentications, enforcing the principle of least privilege.

m. ***Transmission encryption.*** All data transmissions of DHCS PHI or PI outside the secure internal network must be encrypted using a FIPS 140-2 certified algorithm which is 128bit or higher, such as AES. Encryption can be end to end at the network level, or the data files containing PHI can be encrypted. This requirement pertains to any type of PHI or PI in motion such as website access, file transfer, and E-Mail.

n. ***Intrusion Detection.*** All systems involved in accessing, holding, transporting, and protecting DHCS PHI or PI that are accessible via the Internet must be protected by a comprehensive intrusion detection and prevention solution.

3) Audit Controls

a. ***System Security Review.*** All systems processing and/or storing DHCS PHI or PI must have at least an annual system risk assessment/security review which provides assurance that administrative, physical, and technical controls are functioning effectively and providing adequate levels of protection. Reviews should include vulnerability scanning tools.

b. ***Log Reviews.*** All systems processing and/or storing DHCS PHI or PI must have a routine procedure in place to review system logs for unauthorized access.

c. ***Change Control.*** All systems processing and/or storing DHCS PHI or PI must have a documented change control procedure that ensures separation of duties and protects the confidentiality, integrity and availability of data.

4) 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 or PI in the event of an emergency. Emergency means any circumstance or situation that causes normal computer operations to become unavailable for use in performing the work required under this Agreement for more than 24 hours.

b. ***Data Backup Plan.*** Contractor must have established documented procedures to backup DHCS PHI to maintain retrievable exact copies of DHCS PHI or PI. The plan must include a regular schedule for making backups, storing backups offsite, an inventory of backup media, and an estimate of the amount of time needed to restore DHCS PHI or PI should it be lost. At a minimum, the schedule must be a weekly full backup and monthly offsite storage of DHCS data.

5) Paper Document Controls

a. ***Supervision of Data.*** DHCS PHI or PI 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. DHCS PHI or PI 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 or PI is contained shall be escorted and DHCS PHI or PI shall be kept out of sight while visitors are in the area.

c. ***Confidential Destruction.*** DHCS PHI or PI must be disposed of through confidential means, such as cross cut shredding and pulverizing.

d. ***Removal of Data.*** DHCS PHI or PI must not be removed from the premises of the Contractor except with express written permission of DHCS.

e. ***Faxing.*** Faxes containing DHCS PHI or PI 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 the fax.

f. ***Mailing.*** Mailings of DHCS PHI or PI shall be sealed and secured from damage or inappropriate viewing of PHI or PI to the extent possible. Mailings which include 500 or more individually identifiable records of DHCS PHI or PI in a single package shall be sent using a tracked mailing method which includes verification of delivery and receipt, unless the prior written permission of DHCS to use another method is obtained.

B. ***Security Officer.*** The Contractor shall designate a Security Officer to oversee its data security program who will be responsible for carrying out its privacy and security programs and for communicating on security matters with DHCS.

C. ***Discovery and Notification of Breach***. The Contractor shall notify DHCS **immediately by telephone call plus email or fax** upon the discovery of breach of security of PSCI in computerized form if the PSCI was, or is reasonably believed to have been, acquired by an unauthorized person, or upon the discovery of a suspected security incident that involves data provided to DHCS by the Social Security Administration **or within twenty-four (24) hours by email or fax** of the discovery of any suspected security incident, intrusion or unauthorized use or disclosure of PSCI in violation of this Agreement, or potential loss of confidential data affecting this Agreement. Notification shall be provided to the DHCS Program Contract Manager, the DHCS Privacy Officer and the DHCS Information Security Officer. Notice shall be made using the "DHCS Privacy Incident Report" form, including all information known at the time. The Contractor shall use the most current version of this form, which is posted on the DHCS Privacy Office website (www.dhcs.ca.gov, then select "Privacy" in the left column and then "Business Use" near the middle of the page) or use this link: http://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/DHCSBusinessAssociatesOnly.aspx If the incident occurs after business hours or on a weekend or holiday and involves electronic PSCI, notification shall be provided by calling the DHCS Information Technology Services Division (ITSD) Help Desk. Contractor shall take:

1) Prompt corrective action to mitigate any risks or damages involved with the breach and to protect the operating environment and

2) Any action pertaining to such unauthorized disclosure required by applicable Federal and State laws and regulations.

D. ***Investigation of Breach***. The Contractor shall immediately investigate such security incident, breach, or unauthorized use or disclosure of PSCI and within seventy-two (72) hours of the discovery, The Contractor shall submit an updated "DHCS Privacy Incident Report" containing the information marked with an asterisk and all other applicable information listed on the form, to the extent known at that time, to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer:

E. ***Written Report***. The Contractor shall provide a written report of the investigation to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer within ten (10) working days of the discovery of the breach or unauthorized use or disclosure. The report shall include, but not be limited to, the information specified above, as well as a full, detailed corrective action plan, including information on measures that were taken to halt and/or contain the improper use or disclosure.

F. ***Notification of Individuals***. The Contractor shall notify individuals of the breach or unauthorized use or disclosure when notification is required under state or federal law and shall pay any costs of such notifications, as well as any costs associated with the breach. The DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer shall approve the time, manner and content of any such notifications.

7. **Affect on lower tier transactions.** The terms of this Exhibit shall apply to all contracts, subcontracts, and subawards, regardless of whether they are for the acquisition of services, goods, or commodities. The Contractor shall incorporate the contents of this Exhibit into each subcontract or subaward to its agents, subcontractors, or independent consultants.

8. **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 Exhibit or the Agreement to which it is incorporated.

DHCS Program Contract Manager	**DHCS Privacy Officer**	**DHCS Information Security Officer**
See the Scope of Work exhibit for Program Contract Manager information	Privacy Officer c/o Office of Legal Services Department of Health Care Services P.O. Box 997413, MS 0011 Sacramento, CA 95899-7413 Email: privacyofficer@dhcs.ca.gov Telephone: (916) 445-4646	Information Security Officer DHCS Information Security Office P.O. Box 997413, MS 6400 Sacramento, CA 95899-7413 Email: iso@dhcs.ca.gov Telephone: ITSD Help Desk (916) 440-7000 or (800) 579-0874

9. **Audits and Inspections.** From time to time, DHCS may inspect the facilities, systems, books and records of the Contractor to monitor compliance with the safeguards required in the Information Confidentiality and Security Requirements (ICSR) exhibit. Contractor shall promptly remedy any violation of any provision of this ICSR exhibit. The fact that DHCS inspects, or fails to inspect, or has the right to inspect, Contractor's facilities, systems and procedures does not relieve Contractor of its responsibility to comply with this ICSR exhibit.

Section 1915(b) Waiver
Proposal for California Advancing and Innovating Medi-Cal (CalAIM)

Attachment II: Managed Care Enrollment Proposed Aid Code Group Coverage

A breakdown of MCMC enrollment by aid code group and MCMC model is included for reference in the following attachment.

[Updated September 7, 2021]

Attachment II: Managed Care Enrollment Proposed Aid Code Group Coverage

The below chart reflects enrollment status in Medi-Cal Managed Care (MCMC) starting in 2022 for non-dual enrollees, as well as enrollment status for duals in MCMC starting in 2023, with exceptions noted where applicable; the shaded cells reflect a change from the current state (2021) to be modified in 2022 and 2023 to mandatory, voluntary, or excluded enrollment. The complete list of California's Medicaid Eligibility Groups by Medi-Cal can be found at the California Open Data Portal. Enrollment in other Medi-Cal delivery systems – including Dental Managed Care (Dental MC), Specialty Mental Health Services (SMHS), and Drug Medi-Cal Organized Delivery System (DMC-ODS) – are dependent on a beneficiary's county of residency and the beneficiary meeting eligibility criteria for the delivery system.

Managed Care Enrollment Aid Code Group Coverage											
			Current			2022			2023		
Aid Code Group	**Aid Codes[1]**	**Non-Dual/ Dual[2]**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**
Adult Expansion	7U, L1, M1	Non-Dual	All Models	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A
Non-Disabled Adults (19 & Over)	01, 02[3], 08, 30, 34, 35, 37, 39, 38, 54, 59, 81[3], 82, 83, 85, 0A, 3E, 3N, 3P, 3U, 7S, K1, M3	Non-Dual	All Models	N/A	N/A	All Models	N/A	SOC	All Models	N/A	SOC
Aged	10[4], 14, 16, 1E, 1H, 1X	Non-Dual	All Models	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A
Breast and Cervical Cancer Treatment Program (BCCTP)	0M, 0N, 0P, 0W, 0T, 0U, 0R	Non-Dual	All Models	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A

[Updated September 7, 2021]

Managed Care Enrollment Aid Code Group Coverage											
			Current			2022			2023		
Aid Code Group	**Aid Codes[1]**	**Non-Dual/ Dual[2]**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**
Disabled	20[4], 24, 26, 27, 36, 60[4], 64, 66, 67, 2E, 2H, 6A, 6C, 6E, 6J, 6G, 6H, 6N, 6R, 6V, 6W, 6X, 6Y, L6	Non-Dual	All Models	N/A	N/A	All Models	N/A	SOC	All Models	N/A	SOC
Long Term Care (includes LTC SOC)	13, 23, 53, 63	Non-Dual	COHS, CCI	N/A	All Other Models	COHS, CCI	N/A	All Other Models	All Models	N/A	N/A
Foster Children	03, 04, 06, 07, 40, 42, 43, 45, 46, 49, 2P, 2R, 2S, 2T, 2U, 4A, 4C, 4F, 4G, 4H, 4K, 4L, 4M, 4S, 4T, 4W, 5K, 5L	Non-Dual	COHS	Non-COHS	N/A	COHS	Non-COHS	N/A	COHS	Non-COHS	N/A
Omnibus Budget Reconciliation Act (OBRA) Restricted Scope Only	55, 58, C1, C2, C3, C4, C5, C6, C7, C8, C9, D1, D2, D3, D4, D5, D6, D7, D8, D9	Both	Napa, Solano, and Yolo counties	N/A	All Other Models	N/A	N/A	All Models	N/A	N/A	All Models
Share of Cost (SOC)	17, 27, 37, 58, 67,73, 81[3], 83, 87, 02[3], 1Y, 5F, 6R, 6W, 6Y, C2, C4, C6, C8, D1, D3, D5, D7, D9	Non-Dual	COHS & CCI	N/A	All Other Models	N/A	N/A	All Models	N/A	N/A	All Models

[Updated September 7, 2021]

Managed Care Enrollment Aid Code Group Coverage											
			Current			2022			2023		
Aid Code Group	**Aid Codes[1]**	**Non-Dual/ Dual[2]**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**
Non-Disabled Adults (19 & Over)	01, 02[3], 08, 30, 34, 35, 37, 39, 38, 54, 59, 82, 0A, 3E, 3N, 3P, 3U, 7S, K1, M3	Dual	COHS, CCI	All Other Models	N/A	COHS, CCI	All Other Models	SOC	All Models	N/A	SOC
Non-Disabled Children (Under 19)	30, 32, 33, 34, 35, 37, 38, 39, 47, 54, 59, 72, 82, 2C, 3A, 3C, 3E, 3F, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 4N, 4U, 5C, 5D, 6P, 7A, 7J, 7W, 7X, 8P, 8R, E6, E7, H1, H2, H3, H4, H5, M5, P5, P7, P9, T1, T2, T3, T4, T5	Dual	COHS, CCI	All Other Models	N/A	COHS, CCI	All Other Models	SOC	All Models	N/A	SOC
Aged	10[4], 14, 16, 1E, 1H, 1X	Dual	COHS, CCI	All Other Models	N/A	COHS, CCI	All Other Models	N/A	All Models	N/A	N/A
Breast and Cervical Cancer Treatment Program (BCCTP)	0M, 0N, 0P, 0W, 0T, 0U, 0R	Dual	COHS, CCI	All Other Models	N/A	COHS, CCI	All Other Models	N/A	All Models	N/A	N/A
Disabled	20[4], 23, 24, 26, 36, 60[4], 63, 64, 66, 2E, 2H, 6A, 6C, 6E, 6J, 6G, 6H, 6N, 6V, 6X, L6	Dual	OHS, CCI	All Other Models	N/A	COHS, CCI	All Other Models	SOC	All Models	N/A	SOC

[Updated September 7, 2021]

Managed Care Enrollment Aid Code Group Coverage											
			Current			2022			2023		
Aid Code Group	**Aid Codes[1]**	**Non-Dual/ Dual[2]**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**
Long Term Care (LTC) (includes LTC SOC)	13, 23, 53, 63	Dual	COHS, CCI	All Other Models	N/A	COHS, CCI	All Other Models	N/A	All Models	N/A	N/A
Share of Cost (SOC)	17, 27, 37, 53, 58, 67, 73, 81[3], 83, 87, 02[3], 1Y, 5F, 6R, 6W, 6Y, C2, C4, C6, C8, D1, D3, D5, D7, D9	Dual	COHS, CCI	N/A	Non-COHS & Non-CCI	N/A	N/A	All Models	N/A	N/A	All Models
Presumptive Eligibility (Hospital and CHDP Presumptive Eligibility)	2A, 4E, 8L, 8W, 8X, H0, H6, H7, H8, H9, P1, P2, P3	Both	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A	All Models
Trafficking and Crime Victims Assistance Program (TCVAP)	2V, 4V, 5V, 7V, R1	Both	N/A	N/A	All Models	All Models	N/A	TCVAP SOC	All Models	N/A	TCVAP SOC
Accelerated Enrollment (AE)	8E	Both	N/A	N/A	All Models	All Models	N/A	N/A	All Models	N/A	N/A
Child Health and Disability Prevention (CHDP) Infant Deeming[5]	8U, 8V	Both	8U	N/A	8V	All Models	N/A	CHDP SOC	All Models	N/A	CHDP SOC

[Updated September 7, 2021]

Managed Care Enrollment Aid Code Group Coverage											
			Current			2022			2023		
Aid Code Group	**Aid Codes[1]**	**Non-Dual/ Dual[2]**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**
State Medical Parole/County Compassionate Release/Incarcerated Individuals	F1, F2, F3, F4, G0, G1, G2, G3, G4, G5, G6, G7, G8, G9, J1, J2, J3, J4, J5, J6, J7, J8, K2, K3, K4, K5, K6, K7, K8, K9, N0, N5, N6, N7, N8, N9	N/A	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A	All Models
Limited/Restricted Scope Eligible	48, 50, 55, 58, 69, 71, 73, 74, 76, 77, 80, 0L, 0M, 0V, 0X, 0Y, 1U, 3T, 3V, 5J, 5R, 5T, 5W, 6U, 7C, 7F, 7G, 7H, 7K, 7M, 7N, 7P, 7R, 8N, 8T, C1, C2, C3, C4, C5, C6, C7, C8, C9, D1, D2, D3, D4, D5, D6, D7, D8, D9, E1, L7, M0, M2, M4, M6, M8, P0, P4, P6, P8, T0, T6, T7, T8, T9, F1, F2, F3, F4, G1, G2, G3, G4, G5, G6, G7, G8, G9, J3, J4, J6, J8, K3, K5, K7, K9, N0, N5, N6, N7, N8, N9	Both	Except for OBRA in Napa, Solano and Yolo	N/A	All Models	N/A	N/A	All Models	N/A	N/A	All Models

Managed Care Enrollment							
Pregnancy Related Aid Codes							
	Citizen/Lawfully Present				**Non-Citizen**		
	Aid Codes	**Current**	**Proposed (2022)**		**Aid Codes**	**Current**	**Proposed (2022)**
Title XXI (SCHIP) 213-322%	86, 0E	Full Scope/MC	Full Scope/MC	**Title XXI (SCHIP) 213-322%**	0E	Full Scope/MC	Full Scope/MC
Title XIX (PRS/ES) 138-213%	44, M9[6]	Limited Scope/FFS	Full Scope/MC	**Title XXI (PRS – SCHIP) Title XIX (ES) 138-213%**	48, M0	Limited Scope/FFS	Limited Scope/FFS
Title XIX (PRS/ES) 0-138%	M7	Full Scope/MC	Full Scope/MC	**Title XXI (PRS – SCHIP) Title XIX (ES) 0-138%**	D8, D9, M8	Limited Scope/FFS	Limited Scope/FFS

Managed Care Enrollment									
Population Exclusions									
Populations	**Current**			**2022**			**2023**		
	Mandatory	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**
American Indian and Alaska Native[7]	COHS	Non-COHS	N/A	All Models[8]	N/A	N/A	All Models[8]	N/A	N/A
Beneficiaries with Other Healthcare Coverage (OHC)	COHS	N/A	Non-COHS	All Models[8]	N/A	N/A	All Models[8]	N/A	N/A
Beneficiaries in Rural Zip Codes[9]	COHS	Non- COHS	Non-COHS	All Models[8]	N/A	N/A	All Models[8]	N/A	N/A
Beneficiaries in Home and Community Based Services Waivers	COHS & CCI MLTSS = All Non-COHS & Non-CCI = Non- Duals	Non- COHS & Non-CCI = Duals	Cal MediConnect	COHS & CCI MLTSS = All Non-COHS & Non-CCI = Non-Duals	Non-COHS & Non-CCI = Duals	Cal MediConnect	All Models[8]	N/A	N/A

[1] Members residing in a LTC facility in a non-LTC aid code subject to the LTC benefit carve-in will be transitioned into managed care based on the Non-Dual/Dual Mandatory and Voluntary timeline.
[2] Non-Dual/Dual Definitions: (1) Non-Dual – A Medi-Cal only beneficiary or a Medi-Cal only beneficiary with Medicare Part A **or** Part B only; (2) Dual – Medi-Cal only beneficiary with Medicare Part A **and** Part B or Medicare Part A, B, and D.
[3] Aid code can have a SOC or no SOC.
[4] Aid codes 10, 20, 60 are Supplemental Security Income (SSI)/State Supplemental Payment (SSP). Medi-Cal beneficiaries in these three aid codes have mandatory and voluntary enrollments based on different managed care models. These beneficiaries are mandatory in COHS, voluntary in San Benito, voluntary in GMC/Regional/Two-Plan for duals, and mandatory in GMC/Regional/Two-Plan for non-duals.
[5] No changes to the CHDP Infant Deeming aid code group since 8U is currently in mandatory managed care. 8V will remain in Medi-Cal FFS since this aid code has a SOC.
[6] Only new enrollments into 44 and M9 aid codes on January 1, 2021 will move into mandatory managed care. All individuals on 44 and M9 prior to January 1, 2022 will remain in their current delivery system through the end of the individual's postpartum period.
[7] American Indian and Alaska Native beneficiaries will be enrolled into a managed care plan, but they will have the option to opt out of enrollment if they choose to remain in FFS.
[8] Would align with mandatory/voluntary/excluded managed care enrollment by aid code; no special exclusions from enrollment solely based on zip code, OHC, American Indian/Alaska Native, or 1915(c) waiver enrollment.
[9] The following zip codes are currently excluded from enrollment or are voluntary for enrollment: 93558, 90704, 92225, 92226, 92239, 92242, 92267, 92280, 92323, 92332, 92363, 92364, 92366, 93562, 93592, 93555, 93556, 93560, 92252, 92256, 92268, 92277, 92278, 92284, 92285, 92286, 92304,92305, 92309, 92310, 92311, 92312, 92314, 92315, 92317, 92321, 92322, 92325, 92327, 92333, 92338, 92339, 92341, 92342, 92347, 92352, 92356, 92358, 92365, 92368, 92372, 92378, 92382, 92385, 92386, 92391, 92397, 92398.

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Attachment III: Medi-Cal Services Carved In and Carved Out of Medi-Cal Managed Care (January 1, 2022 – December 31, 2026)

A breakdown of services covered by Medi-Cal's managed care delivery system programs and through FFS is included in the following attachment.

Attachment III: Medi-Cal Services Carved In and Carved Out of Medi-Cal Managed Care (January 1, 2022 – December 31, 2026)[1]

(*If service is carved out of managed care, plan is contractually required to provide care coordination to members. Plans are also contractually required to provide Enhanced Care Management for Populations of Focus.)

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Acupuncture Services	Other Practitioners' Services and Acupuncture Services	Acupuncture services shall be limited to treatment performed to prevent, modify or alleviate the perception of severe, persistent chronic pain resulting from a generally recognized medical condition.	**X**	
Audiological Services	Audiology Services	Audiological services are covered when provided by persons who meet the appropriate requirements	**X**	
Behavioral Health Treatment (BHT)	Preventive Services - EPSDT	The provision of medically necessary BHT services to eligible Medi-Cal members under 21 years of age as required by the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) mandate and state plan.	**X**[2]	
Blood and Blood Derivatives	Blood and Blood Derivatives	A facility that collects, stores, and distributes human blood and blood derivatives. Covers certification of blood ordered by a physician or facility where transfusion is given.	**X**	
California Children Services (CCS)	EPSDT	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.	**X**[3]	
Certified Family Nurse Practitioner	Certified Family Nurse Practitioners' Services	A certified family nurse practitioner who provide services within the scope of their practice.	**X**	

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Certified Pediatric Nurse Practitioner Services	Certified Pediatric Nurse Practitioner Services	Covers the care of mothers and newborns through the maternity cycle of pregnancy, labor, birth, and the immediate postpartum period, not to exceed six weeks; can also include primary care services.	**X**	
Childhood Lead Poisoning Case Management (Provided by the Local County Health Departments)	EPSDT	A case of childhood lead poisoning (for purposes of initiating case management) as a child from birth up to 21 years of age with one venous blood lead level (BLL) equal to or greater than 15 µg/dL, or two BLLs equal to or greater than 10 µg/dL that must be at least 30 and no more than 600 calendar days apart, the first specimen is not required to be venous, but the second must be venous.		**X**
Chiropractic Services	Chiropractors' Services	Services provided by chiropractors, acting within the scope of their practice as authorized by California law, are covered, except that such services shall be limited to treatment of the spine by means of manual manipulation.	**X**[4]	
Chronic Hemodialysis	Chronic Hemodialysis	Procedure used to treat kidney failure - covered only as an outpatient service. Blood is removed from the body through a vein and circulated through a machine that filters the waste products and excess fluids from the blood. The "cleaned" blood is then returned to the body. Chronic means this procedure is performed on a regular basis. Prior authorization required when provided by renal dialysis centers or community hemodialysis units.	**X**	
Community Based Adult Services (CBAS)		CBAS Bundled services: An outpatient, facility based service program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, meals and transportation to eligible Medi-Cal beneficiaries. CBAS Unbundled Services: Component parts of CBAS center services delivered outside of centers, under certain conditions.	**X**	

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Community Health Workers	Preventive Services	Preventive services by unlicensed community health workers, promotores, and community health representatives to prevent disease, disability, and other health conditions or their progression.	X[5]	
Comprehensive Perinatal Services	Extended Services for Pregnant Women-Pregnancy Related and Postpartum Services	Comprehensive perinatal services means obstetrical, psychosocial, nutrition, and health education services, and related case coordination provided during pregnancy and up to 12 months following the last day of pregnancy.	X	
Dental Services (Covered under Medi-Cal)		Professional services performed or provided by dentists including diagnosis and treatment of malposed human teeth, of disease or defects of the alveolar process, gums, jaws and associated structures; the use of drugs administered in-office, anesthetics and physical evaluation; consultations; home, office and institutional calls.	X[6]	
Dyadic Services		Integrated physical and behavioral health screening and services for child, caregiver, and family.	X[5]	
Doula Services		Personal support by unlicensed providers to pregnant beneficiaries and their families throughout pregnancy, labor, and in the post-partum period.	X[5]	
Durable Medical Equipment	DME	Assistive medical devices and supplies. Covered with a prescription; prior authorization is required.	X	
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services	EPSDT	EPSDT is the Medicaid program's benefit for children and adolescents, providing a comprehensive array of prevention, diagnostic, and treatment services for low-income infants, children and adolescents under age 21, as specified in Section 1905(r) of the Social Security Act.	X	

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Erectile and/or Sexual Dysfunction Drugs		Drugs for which the only FDA-approved indication is the treatment of sexual dysfunction or erectile dysfunction are not a benefit of the program. Drugs that are FDA-approved for the treatment of sexual dysfunction or erectile dysfunction in addition to one or more other indications, are a benefit only if the drug has is used for a FDA-approved indication outside of the treatment of sexual dysfunction or erectile dysfunction.		**X**
Expanded Alpha-Fetoprotein Testing (Administered by Genetic Disease Branch of CDPH)		A simple blood test recommended for all pregnant women to detect if they are carrying a fetus with certain genetic abnormalities such as open neural tube defects, Down Syndrome, chromosomal abnormalities, and defects in the abdominal wall of the fetus.		**X**
Eyeglasses, Contact Lenses, Low Vision Aids, Prosthetic Eyes and Other Eye Appliances	Eyeglasses, Contact Lenses, Low Vision Aids, Prosthetic Eyes, and Other Eye Appliances	Eye appliances are covered on the valid prescription of a physician or optometrist.	**X**[7]	
Federally Qualified Health Centers (FQHC) (Medi-Cal covered services only)	FQHC	Services described in 42 U.S.C. Section 1396d(a)(2)(C) furnished by an entity defined in 42 U.S.C. Section 1396d(l)(2)(B)).	**X**	
Hearing Aids	Hearing Aids	Hearing aids are covered only when supplied by a hearing aid dispenser on prescription of an otolaryngologist, or the attending physician where there is no otolaryngologist available in the community, plus an audiological evaluation including a hearing aid evaluation which must be performed by or under the supervision of the above physician or by a licensed audiologist.	**X**	
1915(c) Home and Community- Based Waiver Services (Does not include EPSDT Services)		Home and community-based waiver services shall be provided and reimbursed as Medi-Cal covered benefits only: (1) For the duration of the applicable federally approved waiver, (2) To the extent the services are set forth in the applicable waiver approved by the HHS; and (3)		**X**

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
		To the extent the Department can claim and be reimbursed federal funds for these services.		
Home Health Agency Services	Home Health Services-Home Health Agency	Home health agency services are covered as specified below when prescribed by a physician, physician assistant, nurse practitioner, or clinical nurse specialist and provided at the home of the beneficiary in accordance with a written treatment plan which the physician reviews every 60 days.	**X**	
Home Health Aide Services	Home Health Services-Home Health Aide	Covers skilled nursing or other professional services in the residence including part-time and intermittent skilled nursing services, home health aide services, physical therapy, occupational therapy, or speech therapy and audiology services, and medical social services by a social worker.	**X**	
Home Health Pharmacy Services-Total Parenteral and Enteral Nutrition under Medi-Cal Rx.	Home Health	Nutritional products medically necessary because of chronic illness or trauma for patients who cannot be sustained through oral feeding and when used as a therapeutic regimen to prevent serious disability or death in patients with medically diagnosed conditions that preclude the full use of regular food that are billed by a pharmacy on a pharmacy claim, including formula, pumps, tubing, and general sub-categories, as described in the Medi-Cal Rx All Plan Letter (APL 20-020).		**X**
Home Health Other Pharmacy Services-Total Parenteral and Enteral Nutrition	Home Health	Nutritional products medically necessary because of chronic illness or trauma for patients who cannot be sustained through oral feeding and when used as a therapeutic regimen to prevent serious disability or death in patients with medically diagnosed conditions that preclude the full use of regular food that are billed on medical and institutional claims as described in the Medi-Cal Rx All Plan Letter (APL 20-020).	**X**	
Hospice Care	Hospice Care	Covers services limited to individuals who have been certified as terminally ill in accordance with Title 42, CFR Part 418, Subpart B, and who directly or through their representative volunteer to receive such benefits in lieu of other care as specified.	**X**	

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Hospital Outpatient Department Services and Organized Outpatient Clinic Services	Clinic Services and Hospital Outpatient Department Services and Organized Outpatient Clinic Services	A scheduled administrative arrangement enabling outpatients to receive the attention of a healthcare provider. Provides the opportunity for consultation, investigation and minor treatment.	**X**	
Human Immunodefi-ciency Virus and AIDS drugs		Human Immunodeficiency Virus and AIDS drugs that are listed in the Medi-Cal Provider Manual		**X**
Hysterectomy	Inpatient Hospital Services	Except for previously sterile women, a nonemergency hysterectomy may be covered only if: (1) The person who secures the authorization to perform the hysterectomy has informed the individual and the individual's representatives, if any, orally and in writing, that the hysterectomy will render the individual permanently sterile, (2) The individual and the individual's representative, if any, has signed a written acknowledgment of the receipt of the information in and (3) The individual has been informed of the rights to consultation by a second physician. An emergency hysterectomy may be covered only if the physician certifies on the claim form or an attachment that the hysterectomy was performed because of a life-threatening emergency situation in which the physician determined that prior acknowledgement was not possible and includes a description of the nature of the emergency.	**X**	
Indian Health Services (Medi- Cal covered services only)		Indian means any person who is eligible under federal law and regulations (25 U.S.C. Sections 1603c, 1679b, and 1680c) and covers health services provided directly by the United States Department of Health and Human Services, Indian Health Service, or by a tribal or an urban Indian health program funded by the Indian Health Service to provide health services to eligible individuals either directly or by contract.	**X**	

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Inpatient Hospital Services	Inpatient Hospital Services	Covers delivery services and hospitalization for newborns; emergency services without prior authorization; and any hospitalization deemed medically necessary with prior authorization.	**X**	
Laboratory, Radiological and Radioisotope Services	Laboratory, X-Ray and Laboratory, Radiological and Radioisotope Services	Covers exams, tests, and therapeutic services ordered by a licensed practitioner.	**X**[8]	
Licensed Midwife Services	Other Practitioners' Services and Licensed Midwife Services	The following services shall be covered as licensed midwife services under the Medi- Cal Program when provided by a licensed midwife: (1) Attendance at cases of normal childbirth and (2) The provision of prenatal, intrapartum, and postpartum care, including family planning care, for the mother, and immediate care for the newborn.	**X**	
Local Educational Agency (LEA) Services	Local Education Agency Medi- Cal Billing Option Program Services	LEA health and mental health evaluation and health and mental health education services, which include any or all of the following: (A) Nutritional assessment and nutrition education, consisting of assessments and non-classroom nutrition education delivered to the LEA eligible beneficiary based on the outcome of the nutritional health assessment (diet, feeding, laboratory values, and growth), (B) Vision assessment, consisting of examination of visual acuity at the far point conducted by means of the Snellen Test, (C) Hearing assessment, consisting of testing for auditory impairment using at-risk criteria and appropriate screening techniques as defined in Title 17, California Code of Regulations, Sections 2951(c), (D) Developmental assessment, consisting of examination of the developmental level by review of developmental achievement in comparison with expected norms for age and background, (E) Assessment of psychosocial status, consisting of appraisal of cognitive, emotional, social, and behavioral functioning and self-concept through tests, interviews, and behavioral evaluations and (F) Health education and anticipatory guidance appropriate to age		**X**

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
		and health status, consisting of non- classroom health education and anticipatory guidance based on age and developmentally appropriate health education.		
Long Term Care (LTC) Facility Services		Medically necessary care in a LTC facility or setting, including all of the following: • Skilled Nursing Facility (SNF), including a distinct part or unit of a hospital; • Intermediate Care Facility (ICF); • Intermediate Care Facility for Developmentally Disabled (ICF/DD); • Intermediate Care Facility for Developmentally Disabled with Habilitative (ICF/DDH); • Intermediate Care Facility for Developmentally Disabled with Nursing (ICF/DDN); • Subacute facility; • Pediatric Subacute Facility.	*Prior to 1/1/2023:* **X**[9,10,11] *After 1/1/2023:* **X**	
Medi-Cal Substance Abuse Services	Substance Abuse Treatment Services	Medically necessary substance abuse treatment to eligible beneficiaries. This includes counseling services and behavioral therapy related to the drugs and biologicals covered under the SUPPORT Act.		**X**
Medical Supplies	Medical Supplies	Medically necessary supplies when prescribed by a licensed practitioner. Does not include medical supplies carved-out to Medi-Cal Rx that are billed by a pharmacy on a pharmacy claim including medical supplies described in the Medi-Cal Rx All Plan Letter (APL 20-020).	**X**	
Medical & Non-Medical (NMT) Transportation Services	Transportation-Medical & Non-Medical Transportation (NMT) Services	Covers ambulance, litter van and wheelchair van medical transportation services when the beneficiary'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. NMT is transportation by private or public vehicle for beneficiaries who do not have another way to get to their appointment.	**X**	

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Nurse Anesthetist Services	Other Practitioners' Services and Nurse Anesthetist Services	Covers anesthesiology services performed by a nurse anesthetist within the scope of his or her licensure.	**X**	
Nurse Midwife Services	Nurse-Midwife Services	An advanced practice registered nurse who has specialized education and training in both Nursing and Midwifery, is trained in obstetrics, and provides care for mothers and newborns through the maternity cycle of pregnancy, labor, birth, and the immediate postpartum period, not to exceed six weeks.	**X**	
Optometry Services	Optometrists' Services	Covers eye examinations and prescriptions for corrective lenses.	**X**	
Organ and Bone Marrow Transplant Surgeries	Transplant	Medically necessary donor and recipient organ and bone marrow transplant surgeries for adult and pediatric transplant recipients and donors, including related services such as organ procurement and living donor care.	**X**	
Outpatient Mental Health	Outpatient Mental Health	Services provided by licensed health care professionals acting within the scope of their license for adults and children diagnosed with a mental condition as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM) resulting in mild to moderate distress or impairment of mental, emotional, or behavioral functioning. Services include: • Preventive mental health services for potential mental health disorders not yet diagnosed • Behavioral health screenings and interventions • Mental health evaluation and treatment, including individual, group and family psychotherapy • Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition.	**X**[12]	

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
		• Outpatient services for purposes of monitoring drug therapy • Psychiatric consultation • Outpatient laboratory, drugs, supplies and supplements • Mental health services for beneficiaries 21 years and over with mild to moderate distress or mild to moderate impairment of mental, emotional, or behavioral functioning resulting from mental health disorders, as defined by the current Diagnostic and Statistical Manual of Mental Disorders • Mental health services for beneficiaries under age 21 regardless of level of distress or impairment or the presence of a diagnosis, unless the recipient meets the criteria for Specialty Mental Health Services •		
Organized Outpatient Clinic Services	Clinic Services and Organized Outpatient Clinic Services	In-home medical care waiver services and nursing facility waiver services are covered when prescribed by a physician and provided at the beneficiary's place of residence in accordance with a written treatment plan indicating the need for in- home medical care waiver services or nursing facility waiver services and in accordance with a written agreement between the Department and the provider of service.	**X**	
Outpatient Heroin Detoxification Services	Outpatient Heroin Detoxification Services	Can cover of a number of medications and treatments, allowing for day-to-day functionality for a person choosing to not admit as an inpatient. Routine elective heroin detoxification services are covered, subject to prior authorization, only as an outpatient service. Outpatient services are limited to a maximum period of 21 days. Inpatient hospital services shall be limited to patients with serious medical complications of addiction or to patients with associated medical problems which require inpatient treatment.		**X**

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Part D Drugs		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.		**X**
Pharmaceutical Services and Prescribed Drugs under Medi-Cal Rx	Pharmaceutical Services and Prescribed Drugs	Pharmacy benefits carved-out to Medi-Cal Rx, which are pharmacy benefits that are billed by a pharmacy on a pharmacy claim, including covered outpatient drugs and physician administered drugs, as described in the Medi-Cal Rx All Plan Letter (APL 20-020).		**X**
Other Pharmaceutical Services and Prescribed Drugs	Pharmaceutical Services and Prescribed Drugs	Covers pharmacy benefits that are billed on medical and institutional claims, including physician administered drugs, other outpatient drugs, legend, non-legend and specialty drugs that are not carved-out to Medi-Cal Rx as discussed above, and further described in Medi-Cal Rx All Plan Letter (APL 20-020).	**X**	
Pharmacist Services	Pharmacist Services	Pharmacists in a community pharmacy setting furnishing specified categories of drugs (furnishing of naloxone, self-administered hormonal contraceptives, nicotine replacement therapy, HIV pre-exposure and post-exposure prophylaxis, and initiating and administrating immunizations).	**X**	
Physician Services	Physician Services	Covers primary care, outpatient services, and services rendered during a stay in a hospital or nursing facility for medically necessary services. Can cover limited mental health services when rendered by a physician, and limited allergy treatments.	**X**	
Podiatry Services	Other Practitioners' Services and Podiatrists' Services	Office visits are covered if medically necessary. All other outpatient services are subject to the same prior authorization procedures that govern physicians, and are limited to medical and surgical services necessary to treat disorders of the feet, ankles, or tendons that insert into the foot, secondary to or complicating chronic medical diseases, or which significantly impair the ability to walk. Services rendered on an emergency basis are exempt from prior authorization.	**X**	

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Preventive Services	Preventive Services	All preventive services articulated in the state plan.	**X**	
Prosthetic and Orthotic Appliances	Prosthetic and Orthotic Appliances	All prosthetic and orthotic appliances necessary for the restoration of function or replacement of body parts as prescribed by a licensed physician, podiatrist or dentist, within the scope of their license, are covered when provided by a prosthetist, orthotist or the licensed practitioner, respectively	**X**	
Physical Therapy and Occupational Therapy	Physical Therapy and Occupational Therapy	Physical therapy and occupational therapy are covered when provided by persons who meet the appropriate requirements	**X**	
Private Duty Nursing	EPSDT	Private duty nursing is the planning of care and care of clients by nurses, whether a registered nurse or licensed practical nurse for individuals under 21 years of age.	**X**[2]	
Rehabilitation Center Outpatient Services	Rehabilitative Services	A facility providing therapy and training for rehabilitation on an outpatient basis. The center may offer occupational therapy, physical therapy, vocational training, and special training.	**X**	
Rehabilitation Center Services	Rehabilitative Services	A facility which provides an integrated multidisciplinary program of restorative services designed to upgrade or maintain the physical functioning of patients.	**X**	
Respiratory Care Services	Physician Services	A provider trained and licensed for respiratory care to provide therapy, management, rehabilitation, diagnostic evaluation, and care of patients with deficiencies and abnormalities affecting the pulmonary system and aspects of cardiopulmonary and other systems.	**X**	
Rural Health Clinic Services	Rural Health Clinic Services	Services described in 42 U.S.C. Section 1396d(a)(2)(B) furnished by a rural health clinic as defined in 42 U.S.C. Section 1396d(l)(1).	**X**	

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Scope of Sign Language Interpreter Services	Sign Language Interpreter Services	Sign language interpreter services may be utilized for medically necessary health care services	**X**	
Services provided in a State or Federal Hospital		California state hospitals provide inpatient treatment services for Californians with serious mental illnesses. Federal hospitals provide services for certain populations, such as the military, for which the federal government is responsible.		**X**
Specialty Mental Health Services		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.		**X**[13]
Specialized Rehabilitative Services in Skilled Nursing Facilities and Intermediate Care Facilities	Special Rehabilitative Services	Specialized rehabilitative services shall be covered. Such service shall include the medically necessary continuation of treatment services initiated in the hospital or short term intensive therapy expected to produce recovery of function leading to either (1) a sustained higher level of self care and discharge to home or (2) a lower level of care. Specialized rehabilitation service shall be covered.	**X**[9]	
Speech Pathology	Speech Pathology	Speech pathology services are covered when provided by persons who meet the appropriate requirements.[Error! Bookmark not defined.]	**X**	
State Supported Services		State funded abortion services that are provided through a secondary contract.	**X**	
Swing Bed Services	Inpatient Hospital Services	Swing bed services is additional inpatient care services for those who qualify and need additional care before returning home.	**X**	
Targeted Case Management Services (provided by Local Governmental Agencies)	Targeted Case Management	Persons who are eligible to receive targeted case management services shall consist of the following Medi-Cal beneficiary groups: (1) high risk children under the age of 21, (2) medically fragile individuals; (3) children with an Individualized Education Plan or Individualized Family		**X**

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
		Service Plan; (4) individuals at risk of institutionalization; (5) individuals in jeopardy of negative health or psycho-social outcomes; and (6) individuals with a communicable disease. Targeted case management services shall include at least one of the following service components: A documented assessment identifying the beneficiary's needs, development of a comprehensive, written, individual service plan, implementation of the service plan includes linkage and consultation with and referral to providers of service, assistance with accessing the services identified in the service plan, crisis assistance planning to coordinate and arrange immediate service or treatment needed in those situations that appear to be emergent in nature or which require immediate attention or resolution in order to avoid, eliminate or reduce a crisis situation for a specific beneficiary, periodic review of the beneficiary's progress toward achieving the service outcomes identified in the service plan to determine whether current services should be continued, modified or discontinued.		
Transitional Inpatient Care Services	Nursing Facility and Transitional Inpatient Care Services	Focus on transition of care from outpatient to inpatient. Inpatient care coordinators, along with providers from varying settings along the care continuum, should provide a safe and quality transition.	**X**	
Tuberculosis (TB) Related Services (Provided by the Local County Health Departments)	TB Related Services	Covers TB care and treatment in compliance with the guidelines recommended by American Thoracic Society and the Centers for Disease Control and Prevention.		**X**

[1] Coverage and reimbursement of COVID-19 vaccines and administration are carved out of Medi-Cal managed care for all eligible populations and are exclusively covered and reimbursed through the State's fee-for-service delivery system by all applicable providers.
[2] Benefit coverage is limited to only beneficiaries under 21 years of age for services rendered pursuant to EPSDT requirements.
[3] California Children Services (CCS) covered in COHS counties with the exception of Ventura County (Gold Coast Health Plan). CCS not covered in Non-COHS counties and Ventura County.

[4] Chiropractic coverage is limited to only beneficiaries in "Exempt Groups": 1) beneficiaries under 21 years of age for services rendered pursuant to EPSDT program; 2) beneficiaries residing in a SNF (Nursing Facilities Level A and Level B, including subacute care facilities; 3) beneficiaries who are pregnant; 4) CCS beneficiaries; 5) beneficiaries enrolled in the PACE; 6) beneficiaries who receive services at an FQHC or RHC; and 7) beneficiaries in hospital outpatient settings. Chiropractic services are not available at Indian Health Clinics except for those in the exempt groups.
[5] Coverage of benefit subject to federal approval in the Medi-Cal State Plan.
[6] Dental services are carved in to managed care for Health Plan of San Mateo.
[7] The fabrication of eyeglasses lenses are carved out statewide to FFS Medi-Cal contracted optical laboratories, with the exception of specialty lenses (including lenses that exceed contract lab ranges), which remain the responsibility of the managed care plan.
[8] Coverage and reimbursement of COVID-19 testing in school settings, to be carved out of managed care, covered and reimbursed through the state's Fee For Service delivery system.
[9] Only covered for the month of admission and the following month in Non-COHS. Services covered in COHS.
[10] Services covered under managed care only in MLTSS Eligible Beneficiary Authorized Counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara. IHSS benefits are not part of this covered service.
[11] ICF-DD residents are exempt from managed care plan enrollment in Coordinated Care Initiative Counties.
[12] Services provided by primary care physicians; psychiatrists; psychologists; licensed clinical social workers; or other specialty mental health provider. Solano County for Partnership Health plan (COHS) covers specialty mental health, and Kaiser GMC covers inpatient, outpatient, and specialty mental health services.
[13] Kaiser members in Solano and Sacramento counties carved into managed care until 7/1/2023.

Section 1915(b) Waiver
Proposal for California Advancing and Innovating Medi-Cal (CalAIM)

Attachment IV: Specialty Mental Health Services Certified Public Expenditure Protocol

Specialty Mental Health Services Certified Public Expenditure Protocol
Effective July 1, 2012

Under California's Specialty Mental Health Services Waiver, the State contracts with a mental health plan (MHP) in each county. All MHPs are currently county mental health departments. Each MHP assumes responsibility for providing or arranging for the provision of specialty mental health services to all eligible Medicaid beneficiaries who meet the services' medical necessity criteria. MHPs may provide specialty mental health hospital and/or non-hospital services through county-operated facilities and providers and/or through contracts with governmentally-operated and privately operated providers (hereafter referred to as contract providers). Contract providers include governmentally-operated and privately operated hospitals, privately-operated organizational providers, privately-operated group providers, privately-operated individual providers, privately-operated administrative service organizations, and privately-operated non-organizational providers that deliver only therapeutic behavioral services.

The State makes interim payments of federal financial participation (FFP) to the MHPs based upon expenditures submitted by the mental health plans. For services provided by a contract provider, the MHP pays the provider before submitting a claim to the State for the payment of FFP. When submitting a claim for FFP for services provided by a county-operated or contract provider, the MHP is required to certify that it has made expenditures on which the claim for FFP is based, that the expenditures are no greater than the actual cost of providing services, and that the expenditures meet all federal and State requirements for claiming FFP.

The State uses a State-developed cost report for its specialty mental health services waiver program. All MHPs are required to submit a cost report package by December 31st following the close of each fiscal year. The MHPs cost report package includes a detail cost report for county-operated providers, as well as all governmentally-operated hospitals, privately-operated hospitals, and the privately-operated organizational providers that contract with the MHP.[1] The State will use the protocol outlined below to determine allowable Medicaid costs to be certified as public expenditures.

This protocol will remain operative until the effective date for the State's implementation of behavioral health payment reform no sooner than July 1, 2023, which will include a shift from the CPE-based framework to a prospective reimbursement rate methodology in specialty mental health services; DHCS will provide CMS with at least 30 days written notice prior to the effective date for behavioral health payment reform and the sunset of CPE-based payments for specialty

[1] Privately-operated individual providers, group providers, administrative service organizations, privately operated hospitals that provide acute psychiatric inpatient hospital services to Healthy Families beneficiaries, and non-organizational providers that deliver only therapeutic behavioral services do not submit cost reports. They are considered Program 2 providers. An MHP that contracts with one of those providers reports its actual expenditures for services provided under the contract with each provider.

mental health services, but the State will not be required to seek a formal waiver amendment.

I. Definitions

In this protocol, the following terms have the following meaning:

Blended FMAP means a federal medical assistance percentage (FMAP) that is equal to a weighted average of multiple FMAPs.

Control rate means a rate calculated by the State that is used to monitor interim payments of federal financial participation made to mental health plans for services provided by contract providers. The rate is calculated using the contract provider's most recently filed cost report increased by a cost of living index.

Federal Medical Assistance Percentage (FMAP) means the percentage used to determine federal financial participation for the total allowable costs apportioned to a particular Medicaid program. Allowable costs apportioned to some programs are reimbursed at an enhanced rate.

Governmentally-operated hospital means a hospital that is owned and operated by a unit of government.

Healthy Families beneficiary means an individual who is enrolled in a health plan under the State's Children's Health Insurance Program.

Licensed mental health professional means a licensed physician, licensed psychologist, licensed clinical social worker, licensed marriage and family therapist, registered nurse, licensed vocational nurse, and licensed psychiatric technician.

Privately-operated administrative service organization means an organization that is owned and operated by a private entity and contracts with a mental health plan to coordinate the delivery of rehabilitative mental health and/or case management services to beneficiaries residing in another county.

Privately-operated group provider means an organization that is owned and operated by private entities and that provides rehabilitative mental health and/or case management services through two or more individual providers.

Privately operated hospital means a hospital that is owned and operated by a private entity.

Privately-operated individual provider means a licensed mental health professional whose scope of practice permits the practice of psychotherapy without supervision who provides rehabilitative mental health and/or case management services.

Privately operated organizational provider means a provider of rehabilitative mental health and/or case management services that is owned and operated by a private entity and that provides the services through employed or contracting licensed mental health professionals and other staff.

Schedule of Maximum Allowance (SMA) for administrative day services means the maximum per diem rate administrative day services. The maximum rate for administrative day services is calculated annually and is based upon the prospective class median rate for nursing facilities that are distinct parts of acute care hospitals and offer skilled nursing services.

Therapeutic behavioral health services provider means an individual that contracts with the mental health plan to only provide therapeutic behavioral services.

II. Summary of State-Developed Cost Report

The State-developed cost report package includes a "detail cost report" that is submitted by the MHP for the services provided by the county-operated providers and for each of the privately-operated organizational providers, governmentally-operated hospitals, and privately-operated hospitals with which the MHP contracts, as well as a summary cost report. In its detail cost report the MHP includes the costs it incurred for services that it provided as well as services that were provided under contract with an administrative services organization, individual providers, group providers, and non-organizational providers that deliver only therapeutic behavioral services. Each privately-operated organizational provider, governmentally-operated hospital, and privately-operated hospital includes the costs it incurred for the services it provided.

The following includes a brief summary of the forms and schedules contained in the detail cost report for the county-operated providers, and the privately-operated organizational providers, governmentally-operated hospitals, and privately-operated hospitals with which the MHP contracts.

MH 1900 Info

The MH 1900 fulfills a number of purposes: Section I is completed by all providers and captures identifying information about the provider that is repeated in all forms, such as the provider's name. Section II is completed by the MHP only. The MHP provides information that is used in the cost settlement process, such as total payments to privately-operated organizational providers, governmentally operated hospitals, and privately-operated hospitals with which the MHP contracts, and Fee-for-Service hospitals for specialty mental health inpatient and outpatient services and adjustments to Federal Financial Participation (FFP) that account for costs of non-county hospitals and organizational providers that have not been incurred by the MHP.

MH 1960

The purpose of the MH 1960 is to adjust the provider's total expenditures for Medi-Cal principles of reimbursement and determine costs allocated to direct cost centers. MHPs

may allocate allowable costs to waiver administration, utilization review/quality assurance, and direct services, which includes Medi-Cal Administrative Activities and medical assistance. All other providers may allocate allowable costs to direct services, which includes Medi-Cal Administrative Activities and medical assistance. Indirect costs are allocated to waiver administration utilization review/quality assurance, and direct service cost centers on an equitable basis that is consistent with the Office of Management and Budget (OMB) Circular A-87 (and its superseding OMB Super-Circular at 2 CFR 200), including an indirect cost rate plan developed in accordance with OMB A-87 (and its superseding OMB Super-Circular at 2 CFR 200).

Each provider reports total costs from its financial records. County-operated providers report total expenditures from the County Auditor Controller's financial statement for the county Department of Mental Health or the county agency within which the Department of Mental Health is located. All other providers report total expenditures from their trial balance. State auditors must be able to reconcile this amount to the organization's general ledger.

The cost report contains additional schedules that are intended to adjust total expenditures for Medicaid principles of reimbursement contained in CMS Publication 15-1 and Title 42, Code of Federal Regulations, Part 413, OMB Circular A-87 (and its superseding OMB Super-Circular at 2 CFR 200) and Medicaid non-institutional reimbursement policy. The MH 1960 captures data from the form MH 1965 to reclassify costs that were not properly classified in the entity's accounting system, captures adjustments from the MH 1961 to adjust costs for Medicaid principles of reimbursement contained in CMS Publication 15-1 and Title 42, Code of Federal Regulations, Part 413, OMB Circular A-87 (and its superseding OMB Super-Circular at 2 CFR 200) and Medicaid non-institutional reimbursement policy, captures adjustments from the form MH 1962 for non-mental health costs, and captures adjustments from the form MH 1963 for MHP payments to privately-operated hospitals, governmentally-operated hospitals, and privately-operated organizational providers with which the MHP contracts. The MH 1963 is completed by the MHP only.

The Medicaid non-institutional reimbursement policy in determining allowable costs includes:

a) Facilities that are primarily providing medical services - Allowable direct costs will be limited to the costs related to direct practitioners, medical equipment, medical supplies and other costs, such as professional service contract, that can be directly charged to covered medical services. Indirect costs are determined by either applying the agency specific approved indirect cost rate to its net direct costs. When there is not an approved indirect cost rate, the allocated indirect costs can be derived from the allocation process through the provider's approved cost allocation plan. These allocated indirect costs are reduced by any unallowable amount based on Medicaid non-institutional reimbursement policy.
b) Rehabilitative mental health services provided in Adult Residential Treatment Services, Crisis Residential Treatment Services, and Psychiatric Health Facility Services –Allowable costs will be limited to the costs related to direct

practitioners, medical equipment, medical supplies and overhead costs determined using one of the following methods. The provider may allocate overhead costs based upon a cognizant agency approved indirect cost rate. When there is not an approved indirect cost rate, the provider will derive the indirect cost from the allocation process through the provider's approved cost allocation plan. These indirect costs are reduced by any unallowable amount. For those facilities, allowable costs are only those costs that are "directly attributable" to the professional component of providing the medical services and are in compliance with Medicaid non-institutional reimbursement policy. For those costs incurred that "benefit" multiple purposes and would be incurred at the same level if the medical services did not occur are not allowed (e.g. room and board, allocated cost from other related organizations). "

MH 1960_HOSP_COSTS

The purpose of the MH 1960_HOSP_COST is to calculate a hospital's cost per day and cost to charge ratio for hospital costs and physician and other professional costs. The MH 1960_HOSP_Costs captures hospital costs for routine, ancillary, outpatient, other reimbursable, and special purpose cost centers from Worksheet B, Part I, Column 27 of the CMS 2552-96; and adds back direct graduate medical education (GME) costs adjusted out on Worksheet B, Part I, Column 26 of the CMS 2552-96. The MH 1960_HOSP_COSTS captures physician costs from worksheet A-8-2, Column 4 and non-physician professional costs from worksheet A-8.

MH 1960_HOSP_05, MH 1960_HOSP_10, MH_1960_HOSP_15

The MH 1960_HOSP is designed to apportion hospital costs entered on the MH 1960_HOSP_COSTS to the Medi-Cal and Healthy Families Program. The cost per day for routine cost centers and the cost to charge ratio for ancillary and outpatient cost centers calculated on the MH 1960_HOSP_COSTS automatically populates column 1 of the MH 1960_HOSP for each mode of service. For each settlement group, the hospital enters its total days for routine cost centers and total charges for ancillary cost centers to apportion hospital costs to each settlement group. The total cost for administrative day services is limited to the schedule of maximum allowance (SMA) rate established for administrative day services. The total costs for each settlement group and mode of service is transferred to the MH 1968.

MH 1960_PHYS_05, MH 1960_PHYS_10, MH 1960_PHYS_15

The MH 1960_PHYS is designed to apportion hospital-based physician and non-physician professional costs entered on the MH 1960_HOSP_Costs to the Medi-Cal and Healthy Families Program. The cost to charge ratio for ancillary, outpatient, and non-physician practitioner cost centers as calculated in column 11 of the MH 1960_HOSP_COSTS is transferred to column 1 of the MH 1960_PHYS for each mode of service. The hospital enters its physician and professional component charges for each ancillary, outpatient, and non-physician practitioner cost centers to apportion total costs to each settlement group. The total physician and non-physician professional component costs for each settlement group and mode and service is transferred to the MH 1968.

Schedule A

The purpose of Schedule A is to allow each provider to report its normal and customary charge to the public for each type of service it provided during the cost reporting fiscal year. At the interim and final settlement, the MHP is not reimbursed in excess of the provider's customary charge to the public unless it meets criteria for exemption.

Schedule B

The purpose of Schedule B is to capture, for each type of service that the provider delivered during the cost reporting fiscal year, the total units of service provided to Medicaid beneficiaries eligible for non-enhanced and enhanced (i.e., M-CHIP, Refugee, BCCTP) Federal reimbursement, SCHIP beneficiaries, and Non Medi-Cal program beneficiaries; as well as third party revenue collected for those units of service. Units of service provided by hospitals are separately identified from units of service provided by non-hospitals using a specific settlement type.

Schedule C

The purpose of Schedule C is to allocate direct service costs to individual types of service. The MHPs are allowed to use one of three approved methods to allocate direct costs to individual types of services, The three methods are Direct Allocation, Time Study, and Relative Value.

Under the Direct Allocation Method, a MHP can capture its direct costs at the service function level if the MHP has the technology and the reporting means to capture the costs at the service function level.

For the Relative Value Method, a MHP can conduct a time study to capture and accumulate hours at the service function level. A percentage of the hours for each service function is calculated by the dividing the total hours of the service function by total hours of all service functions. The percentage of each service function is multiplied by the total direct costs to determine the direct costs for each service function.

Under the Relative Value Method, first the total units of service for each service function is multiplied by the legal entity's published charge for the service function to arrive at the relative value for the service function. The relative value for each service function is then divided by the sum of all the relative values for all service functions to determine the percentage for the service function. The percentage is then multiplied by the total direct costs to determine the direct cost for each service function.
Total costs allocated on schedule C must reconcile with total costs allocated to direct services on the MH 1960.

MH 1963

The purpose of form MH 1963 is to allow the MHP to report payments made to each governmentally-operated hospital, privately-operated hospital, and privately-operated organizational provider with which the county contracted to provide mental health services during the cost report fiscal year. The county reports total payments made to

each provider during the cost report fiscal year as well as all payments made to each non-county hospital and organizational provider for Medi-Cal reimbursable services provided during the cost report fiscal year by settlement and period of time.

MH 1966

The purpose of form MH 1966 is to apportion non-hospital costs allocated to particular types of service on Schedule C among the Medicaid program, State Children's Health Insurance Program (SCHIP), and non-Medicaid/SCHIP programs. The cost report includes a separate form MH 1966 for acute psychiatric inpatient hospital services (including administrative days), other 24-hour services, day services, program 1 outpatient services, and program 2[2] outpatient services. The only purpose of the form MH 1966 for acute psychiatric inpatient hospital services (including administrative days) is to calculate the gross published charge for comparison with allowable costs. The form MH 1966 for Program 1 outpatient services apportions costs for outpatient services provided by a county or a non-county organizational provider. The form MH 1966 for Program 2 outpatient services apportions costs for services provided by an administrative service organization, individual provider, group provider, or non-organizational provider that delivers only therapeutic behavioral services under contract with the MHP.

Each form MH 1966 calculates a cost per unit for each type of service based upon the total costs allocated to the service on the Schedule C and total units reported on the Schedule B. The cost per unit is multiplied by the total units provided to Medicaid beneficiaries, SCHIP beneficiaries, and non-Medicaid/SCHIP beneficiaries to determine the costs apportioned to each program.

Each form MH 1966, except the form MH 1966 for program 2 outpatient services, also calculates the total published charge attributable to the Medicaid program, State Children's Health Insurance Program, and Non-Medicaid/SCHIP programs. The published charge for each type of service entered on Schedule A is transferred to each form MH 1966. Each form MH 1966 multiplies the published charge for each type of service by the total units provided to Medicaid beneficiaries, SCHIP beneficiaries, and non-Medicaid/SCHIP beneficiaries to determine the published charge attributable to each program.

MH 1969 – INST

The purpose of form MH 1969-INST is for the provider to document whether or not it meets certain criteria necessary to be considered a nominal fee provider. Federal reimbursement for a nominal fee provider is not limited by the provider's published charge. To qualify as a nominal fee provider, the provider must have a published schedule of its full (non-discounted) charges, base patient care revenue on application

[2] Privately-operated individual providers, group providers, administrative service organizations, privately operated hospitals that provide acute psychiatric inpatient hospital services to Healthy Families beneficiaries, and non-organizational providers that deliver only therapeutic behavioral services do not submit cost reports. They are considered Program 2 providers. An MHP that contracts with one of those providers reports its actual expenditures for services provided under the contract with each provider.

of the published charge schedule, maintain written policies for its process of making patient indigence determinations, and maintain sufficient documentation to support the amount of “indigence allowances” written off in accordance with those procedures. An entity that does not meet all four criteria does not qualify as a nominal fee provider.

MH 1969
The purpose of the form MH 1969 is to determine whether a provider that meets the four criteria in the MH 1969-INST has Medi-Cal adjusted customary charges that are equal to or less than 60 percent of its Medi-Cal costs. If a provider’s Medi-Cal adjusted customary charges are equal to or less than 60% of its Medi-Cal costs, it qualifies as a nominal fee provider. Reimbursement for a nominal fee provider is limited to cost. The provider’s published charge is not considered.

MH 1968
The purpose of form MH 1968 is to determine the lower of the provider’s actual costs for inpatient services and outpatient services that are subject to reimbursement or published charge. The form MH 1968 subtracts third party revenue collected for services provided to Medi-Cal beneficiaries and State Children’s Health Insurance Program beneficiaries as reported on the MH 1901 Schedule B from the lower of actual cost to determine the expenditures eligible for federal reimbursement (i.e., net costs). The net costs eligible for federal reimbursement are transferred to form MH 1979. The summary cost report for each mental health plan summarizes the data in the MH 1968 across all providers that file a cost report.

MH 1979
The purpose of form MH 1979 is to calculate total federal financial participation due to the MHP for the specialty mental health services provided to Medicaid and SCHIP beneficiaries. Form MH 1979 multiplies total expenditures eligible for federal reimbursement by the appropriate Federal Medical Assistance Percentage (FMAP) to calculate federal reimbursement. At the time the State does its desk edit, the FFP calculated is adjusted down if the hospital’s or organizational provider’s expenditures are greater than county payments. The summary cost report for each mental health plan summarizes the data in the MH 1979 across all providers that file a cost report.

MH 1992
The purpose of the MH 1992 is to capture the sources of revenue used to make the expenditures reported on the MH 1960. The summary cost report for each mental health plan summarizes the data in the MH 1992 across all providers that file a cost report.

III. Certified Public Expenditures – Determination of Allowable Medicaid Costs

The following steps are taken to determine a MHP’s allowable Medicaid expenditures and associated Medicaid reimbursements when such expenditures are used for claiming FFP through the certified public expenditure (CPE) process.

Interim Medicaid Payments

Interim payments of FFP are based on approximate Medicaid (Medi-Cal) expenditures that are eligible for FFP claimed through the CPE process. Interim payments of FFP to MHPs for services delivered by county-operated facilities are based upon interim rates established by the State for those providers on an annual basis. Interim payments of FFP to MHPs for services delivered by privately operated hospitals, governmentally operated hospitals, privately-operated organizational providers, privately operated group providers, privately-operated individual providers, privately operated Administrative Service Organizations, and therapeutic behavioral services providers are based upon the payments the MHP makes to those providers.

Interim rates for county-operated providers are established by the State on an annual basis using the following procedure. The State extracts from each county operated provider's cost report, the total costs for each type of service as reported on the MH 1901 Schedule C and the total units for each type of service as reported on the MH 1901 Schedule B. The State calculates a cost per unit for each type of services as the ratio of total costs divided by total units. The cost per unit for inpatient services is inflated by the change in the medical component of the national consumer price index and the cost per unit for all outpatient services is inflated by the change in the home health agency market basket unless CMS approves the use of some other cost of living index.

The State's interim payment of FFP to the MHP for the services provided by a contract provider is based upon the amount the MHP certifies to the State as a public expenditure. Except for privately-operated individual providers, privately-operated group providers, privately-operated administrative service organizations, and therapeutic behavioral services providers, the amount the MHP certifies to the State as a public expenditure may not exceed the lowest of (1) the amount the MHP actually paid the provider for the service rendered, (2) a reasonable approximation of the provider's allowable cost to render the service based upon its most recently filed cost report, or (3) the provider's usual and customary charge for rendering the service. The amount the MHP certifies to the State as a public expenditure for individual providers, group provider, administrative service organizations, and therapeutic behavioral service providers must equal the amount the MHP paid the provider. The MHP may adjust the interim rates established with its contract providers throughout the fiscal year, depending upon the MHP's agreement with the contract provider. MHPs may also settle with their contract providers after the close of the fiscal year and claim FFP for additional expenditures through the interim settlement process.

The State monitors interim payments of FFP to MHP's for services provided by contract providers on a quarterly basis. At the beginning of the fiscal year, the State prepares a set of "control rates" for each governmentally-operated hospital, privately operated hospital, and privately-operated organizational provider, as well as individual and group providers, ASO providers, and TBS providers with which each MHP contracts. The control rates for organizational providers, governmentally operated hospitals, and privately operated hospitals with which an MHP contracts are based upon the lower of

the provider's cost per unit or usual and customary charge as reported in its most recently filed cost report trended to the current year using the home health agency market basket for outpatient services, the medical component of the national consumer price index for inpatient services, or another cost of living index approved by CMS. The control rates for individual and group providers, ASO providers, and TBS providers are based upon the average cost per unit for each type of provider as reported in the MHP's annual cost report. On a quarterly basis, the State prepares a report from its claiming system that shows the rate per unit of service the MHP submitted in its claims for services provided by each contract provider. The State compares the rate per unit from the claiming system with the control rate. The State contacts each MHP when the rate used to claim reimbursement exceeds the control rate by ten percent or more.
When the MHP submits claims for services provided by both county-operated and contract providers, it certifies that the expenditures meet all federal and State statutory and regulatory provisions, including 42 CFR 433.51. By signing the claim, the MHP is certifying that it made expenditures for the amount included in the claim.

Interim Reconciliation of Interim Medicaid Payments

Each MHP's expenditures that are used to claim interim FFP payments are reconciled to its State-developed cost report package for the State fiscal year in which services were provided. If, at the end of the interim reconciliation process, it is determined that a MHP received an overpayment, the overpayment is properly credited to the federal government in accordance with 42 CFR 433.316. If, at the end of the interim reconciliation process, it is determined that a MHP received an underpayment, an additional payment is made to the MHP. The State uses the following process to complete its interim reconciliation of interim Medicaid payments of FFP no later than 24 months after the close of the state fiscal year.

Each MHP is required to submit a State-developed cost report package to the State by December 31st following the close of the State fiscal year, which is June 30th. The State-developed cost report package includes a "detail cost report" for the MHP's county operated providers and all privately-operated hospitals, governmentally-operated hospitals, and privately-operated organizational providers with which the MHP contracts to provide specialty mental health services to its beneficiaries and a summary cost report. The county mental health director and county auditor controller sign a statement certifying the accuracy of the initial cost report submitted. Typically, beginning in the October following cost report submission, MHPs are given 90 days to reconcile their Medi-Cal reimbursable units of service with the State's record of claims adjudication. While reconciling Medi-Cal reimbursable units of service, the MHP may also update the Medi-Cal payments made to governmentally-operated hospitals, privately-operated hospitals and organizational providers as reported on the MH 1963. During the time between initial submission of the cost report and reconciliation of Medi-Cal units, the MHP may settle with their contract providers. This settlement process may result in additional payments to contract providers for Medi-Cal specialty mental health services provided during the cost report fiscal year. Medi-Cal payments reported on the MH 1963 may be updated to reflect these additional payments made to governmentally-operated

hospitals, privately-operated hospitals, and organizational providers. MHP's submit the cost report to the State after making adjustments for Medi-Cal reimbursable units of service and Medi-Cal payments to governmentally-operated hospitals, privately-operated hospitals, and organizational providers.

When the State receives the reconciled cost report, staff completes a desk review of all detail cost reports to verify that the county has made payments for the costs that have been reported by privately-operated hospitals, governmentally-operated hospitals, and privately-operated organizational providers with which the MHP contracts; or appropriate adjustments have been made to FFP calculated on the form MH 1979 to ensure that the county is not receiving federal reimbursement for expenditures that it did not make. The desk review compares the total Medi-Cal payments that the county MHP reported it paid each privately-operated hospital, governmentally-operated hospital, and privately-operated organizational provider with which it contracts on the form MH 1963 with the total expenditures eligible for federal reimbursement for each settlement group and period of time. If the total Medi-Cal payments made by the county are greater than or equal to the total expenditures eligible for federal reimbursement, the county has incurred the costs that are being reimbursed. If the total Medi-Cal payments made by the county are less than the total expenditures eligible for federal reimbursement, the State requires that the privately-operated hospital, governmentally operated hospital, or privately-operated organizational provider cost report reduce the total FFP by the amount of FFP that is based on costs that have not been incurred by the county. The county may not compute the excess FFP based on blended FMAPs, but rather the total computable of excess CPE should be attributed to the particular claiming quarters for CMS-64 reporting purposes. The State requires the county to use the following method to calculate the adjustment to FFP if its Medi-Cal payments are less than the net reimbursement used to calculate FFP on the MH 1979. For each settlement group and period of time, subtract the total Medi-Cal payments reported on the MH 1963 from the net reimbursement calculated on the MH 1979 to identify expenditures that are not properly classified as certified public expenditures. Multiply the expenditures that cannot be properly classified as certified public expenditure by the FMAP applicable to the settlement group and period of time to determine the adjustment to FFP.

Once the cost report has passed the desk review, the State notifies the MHP that its cost report has been accepted by the State and requests that the MHP submit the appropriate certification within 10 days. The county mental health director and county auditor controller sign a statement certifying the accuracy of the reconciled cost report submitted. By signing the certification, the mental health director and auditor controller are certifying that the expenditures meet all federal and State statutory and regulatory provisions, including 42 CFR 433.51.

All of the detail cost reports submitted by a MHP are summarized into a summary cost report that shows the federal financial participation (FFP) due to the MHP for the services provided by the county MHP and all of the privately-operated hospitals, governmentally-operated hospitals, and privately-operated organizational providers with which it contracts. The total FFP calculated on the summary cost report is compared to

total interim payments made to the MHP in the applicable State fiscal year to determine whether the MHP received more or less FFP than it is due for the cost report fiscal year. MHPs that received FFP in excess of the amount due to them are invoiced and the money is promptly returned to the federal government in accordance with 42 CFR 433.316. MHPs that received FFP in an amount that is less than the amount due to them receive an additional payment.

Final Reconciliation of Interim Medicaid Payments

The State will complete its audit of the reconciled cost report within three years of the date the certified reconciled State-developed cost report is submitted. The audit performed by the State determines whether the income, expenses, and statistical data reported on the mental health cost report are reasonable, allowable, and in accordance with State and federal rules, regulations, and Medicare principles of reimbursement issued by the Department of Health and Human Services and Centers for Medicare and Medicaid Services (CMS). The audit also determines that the county's mental health cost report accurately represents the actual cost of operating the Medi-Cal Specialty Mental Health program in accordance with the program's Cost and Financial Reporting System (CFRS), Generally Accepted Accounting Principles (GAAP), Title 42, Code of Federal Regulations (42CFR), Office of Management and Budget (OMB) Circular A-87 (and its superseding OMB Super-Circular at 2 CFR 200), Medicaid non-institutional reimbursement policy, Generally Accepted Auditing Standards (GAAS), Generally Accepted Governmental Auditing Standards (GAGAS) as published by the Comptroller General of the United States and other State and federal regulatory authorities. The State audit staff compares the FFP due to the MHP in the audited cost report with all interim payments, including the interim settlement and supplemental payments to eligible entities, and applies the upper payment limit pursuant to 42 CFR 447.362. The purpose of this comparison or review is for the State to determine if an overpayment or underpayment exists, and ensure that any overpayment of FFP is promptly returned to the federal government per 42 CFR 433.316 and 433.320. If the State determines that the MHP received an underpayment, the State makes an additional payment to the MHP.

COVID-19 Public Health Emergency

Notwithstanding any other provisions in this Attachment, the following modified requirements will apply for covered inpatient and outpatient services provided on or after March 1, 2020, until the COVID-19 public health emergency ends:

- **Interim payments of FFP to MHPs for services delivered by county-operated facilities are at the lower of the county's billed amount or interim rates established by the State for those providers on an annual basis increased by 100 percent.**
- **The State's interim payment of FFP to the MHP for the services provided by a contract provider is based upon the amount the MHP certifies to the State**

as a public expenditure. The amount the MHP certifies to the State as a public expenditure must equal the amount the MHP actually paid the provider for the service rendered. Except for covered inpatient services, the limitations of a reasonable approximation of the provider's allowable cost to render the service based upon its most recently filed cost report, and of the provider's usual and customary charge for rendering the service, are suspended.

- **For purposes of interim and final reconciliation of covered outpatient services, net costs eligible for federal reimbursement will be equal the provider's actual allowable cost. The limitation of the provider's customary charge to the public for covered outpatient services is suspended.**

To the extent necessary to implement these modified requirements, all conflicting provisions in this Attachment are suspended.