EXHIBIT A: SCOPE OF WORK

1. SERVICE OVERVIEW

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

Provide dental managed care services to eligible Medi-Cal Members within the scope of Medi-Cal benefits as defined in the contents of the Contract.

2. SERVICE LOCATION

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

3. SERVICE HOURS

The Services shall be provided as needed on a twenty-four (24) hour, seven (7) days per week basis.

4. CONTRACT REPRESENTATIVES

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

Department of Health Care Services	**Plan Name**
Medi-Cal Dental Services Division **Attention**: XXXX, XXX Telephone: (XXX) XXX-XXXX Email: XXX@dhcs.ca.gov	XXX Phone: (XXX) XXX-XXXX Email: XXX

2. Direct all inquiries to:

Department of Health Care Services	**Plan name**
Medi-Cal Dental Services Division **Attention**: XXX, XXX 1501 Capitol Avenue, MS 4900 P.O. Box Number 997413 Sacramento, CA 95899-7413 Telephone: (XXX) XXX-XXXX Email: XXX@dhcs.ca.gov	**Attention:** XXX, XXX Plan Name Street Address City, State Zip

3. Either party may make changes to the information in Provision 4 of this Exhibit by giving written notice to the other party. Said changes shall not require an amendment to this Contract.

5. SERVICES TO BE PERFORMED

The Contractor shall be responsible for performing the services and requirements in this Request for Proposal (RFP), as well as the specific and detailed services and requirements in the following Contract Exhibits:

1. EXHIBIT A1: IMPLEMENTATION PLAN
2. EXHIBIT A11: IMPLEMENTATION PLAN DELIVERABLES
3. EXHIBIT A2: ORGANIZATION AND ADMINISTRATION OF THE PLAN
4. EXHIBIT A3: FINANCIAL INFORMATION
5. EXHIBIT A4: MANAGEMENT INFORMATION SYSTEM (MIS)
6. EXHIBIT A5: QUALITY IMPROVEMENT AND ORAL HEALTH ACCESS TRANSFORMATION PROGRAM
7. EXHIBIT A6: PERFORMANCE MEASURES AND BENCHMARKS
8. EXHIBIT A7: UTILIZATION MANAGEMENT
9. EXHIBIT A8: PROVIDER NETWORK
10. EXHIBIT A9: PROVIDER RELATIONS
11. EXHIBIT A10: PROVIDER COMPENSATION ARRANGEMENTS
12. EXHIBIT A11: ACCESS AND AVAILABILITY
13. EXHIBIT A12: SCOPE OF SERVICES
14. EXHIBIT A13: CASE MANAGEMENT AND COORDINATION OF CARE
15. EXHIBIT A14: MEMBER SERVICES AND BENEFICIARY SUPPORT

16. EXHIBIT A15: MEMBER GRIEVANCE AND APPEAL SYSTEM
17. EXHIBIT A16: ENROLLMENTS AND DISENROLLMENTS
18. EXHIBIT A17: MARKETING
19. EXHIBIT A18: DELIVERABLE SCHEDULE
20. EXHIBIT A19: DELIVERABLE TEMPLATES

6. AMERICANS WITH DISABILITIES ACT

Contractor agrees to ensure that deliverables developed and produced pursuant to this Agreement shall comply with the accessibility requirements of Section 508 of the Rehabilitation Act and the Americans with Disabilities Act of 1973 as amended (29 U.S.C. § 794 (d), and regulations implementing that Act as set forth in Part 1194 of Title 36 of the Federal Code of Regulations. In 1998, Congress amended the Rehabilitation Act of 1973 to require Federal agencies to make their electronic and information technology (EIT) accessible to people with disabilities. California Government Code section 11135 codifies section 508 of the Act requiring accessibility of electronic and information technology.

7. EXECUTIVE ORDER N-6-22 – RUSSIA SANCTIONS

On March 4, 2022, Governor Gavin Newsom issued Executive Order N-6-22 (the EO) regarding Economic Sanctions against Russia and Russian entities and individuals. “Economic Sanctions” refers to sanctions imposed by the U.S. government in response to Russia’s actions in Ukraine, as well as any sanctions imposed under state law. The EO directs state agencies to terminate contracts with, and to refrain from entering any new contracts with, individuals or entities that are determined to be a target of Economic Sanctions. Accordingly, should the State determine Contractor is a target of Economic Sanctions or is conducting prohibited transactions with sanctioned individuals or entities, that will be grounds for termination of this agreement. The State must provide Contractor advance written notice of such termination, allowing Contractor at least 30 calendar days to provide a written response. Termination will be at the sole discretion of the State.

The services in this contract are subject to the Provisions set forth in the Exhibits and Attachments appended hereto.

EXHIBIT A1: IMPLEMENTATION PLAN

This Implementation Plan Deliverables Attachment describes DHCS requirements for specific deliverables, activities, and timeframes that Contractor must complete during the Implementation Period before beginning Operations, unless otherwise specified herein. Contractor is expected to update the deliverables 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 shall be submitted to DHCS for review and approval, no later than thirty (30) calendar days prior to any material change. The approval process for updates shall be in accordance with SECTION 5. APPROVAL PROCESS FOR SUBMITTED MATERIALS DURING OPERATIONS. All submitted financial information must adhere to Generally Accepted Accounting Principles (GAAP), unless otherwise noted.

Contractor shall submit:

1. ORGANIZATION AND ADMINISTRATION OF PLAN

Submit the following consistent with the requirements of EXHIBIT A2: ORGANIZATION AND ADMINISTRATION OF THE PLAN.

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 California Code of Regulations (CCR) Section 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. As referenced CCR 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. Title 28, CCR 1300.51(d)F1f

c. Exhibits F-2-a and F-2-b: Contracts with Affiliated person, Principal Creditors and Providers of Administrative Services. Title 28, CCR 1300.51(d)F2

d. Exhibit F-3 Other Controlling Persons.

   28 CCR 1300.51(d)F

e. In addition to EXHIBIT F: CONTRACTOR'S RELEASE, Contractor shall demonstrate compliance with requirements of 22 CCR 53874 and 53600. Identify any individual named in this item that was an employee of the State of California in the past twelve (12) months. Describe their job position and function while a State employee.

f. Submit Exhibits N-1 and N-2: Contracts for Administrative Services.

   28 CCR 1300.51(d) N1&2

2. FINANCIAL INFORMATION

Submit the following consistent with the requirements of EXHIBIT A3: FINANCIAL INFORMATION.

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. 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 CCR 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.

3. MANAGEMENT INFORMATION SYSTEM (MIS)

Submit the following consistent with the requirements of EXHIBIT A4: MANAGEMENT INFORMATION SYSTEM (MIS).

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

4. QUALITY IMPROVEMENT AND ORAL HEALTH ACCESS TRANSFORMATION PROGRAM (QIOHATP)

Submit the following consistent with the requirements of EXHIBIT A5: QUALITY IMPROVEMENT AND ORAL HEALTH ACCESS TRANSFORMATION PROGRAM.

1. Submit a written description of the QIOHATP, including:

    a. A flow chart and/or organization chart identifying all components of the QIOHATP and who is involved and responsible for each activity.
    b. A description of the responsibility of the governing body in the QIOHATP.
    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 QIOHATP, its activities and outcomes.

2. Submit policies and procedures related to the delegation of the QIOHATP activities.

3. Submit boilerplate subcontract language showing accountability of delegated QIOHATP functions and responsibilities.

4. Policies and procedures to address how Contractor will meet the requirements of:

    a. Quality and Performance 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.

5. UTILIZATION MANAGEMENT (UM)

Submit the following consistent with the requirements of EXHIBIT A7: UTILIZATION MANAGEMENT.

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 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.

6. PROVIDER NETWORK

Submit the following consistent with the requirements of EXHIBIT A8: PROVIDER NETWORK.

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 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 SECTION 13. SUBCONTRACTS WITH FEDERALLY QUALIFIED HEALTH CENTERS, RURAL HEALTH CLINICS AND INDIAN HEALTH CARE PROVIDERS (FQHC/RHC/IHCP).

7. Submit a GeoAccess report (or similar) showing that the proposed provider network meets the appropriate time and distance standards set forth in SECTION 6. TIME AND DISTANCE STANDARD.

8. Submit a report containing the names of all subcontracting provider groups (see SECTION 9. PLAN PROVIDER NETWORK).

9. Submit an analysis demonstrating the ability of Contractor's provider network to meet the ethnic, cultural, and linguistic needs of 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.

7. PROVIDER RELATIONS

Submit the following consistent with the requirements of EXHIBIT A9: PROVIDER RELATIONS.

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.

8. PROVIDER COMPENSATION ARRANGEMENTS

Submit the following consistent with the requirements of EXHIBIT A10: PROVIDER COMPENSATION ARRANGEMENTS.

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 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

9. ACCESS AND AVAILABILITY

Submit the following consistent with the requirements of EXHIBIT A11: ACCESS AND AVAILABILITY.

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 Contractor or Subcontractor has objections to perform or otherwise support, consistent with Access Requirements, 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.

10. SCOPE OF SERVICES

Submit the following consistent with the requirements of EXHIBIT A12: SCOPE OF SERVICES.

1. Submit policies and procedures, including standards, for the provision of the following services for Members under twenty-one (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.

11. CASE MANAGEMENT AND COORDINATION OF CARE

Submit the following consistent with the requirements of EXHIBIT A13: CASE MANAGEMENT AND COORDINATION OF CARE.

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 twenty-one (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.

12. MEMBER SERVICES AND BENEFICIARY SUPPORT

Submit the following consistent with the requirements of EXHIBIT A14: MEMBER SERVICES AND BENEFICIARY SUPPORT.

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.

13. MEMBER GRIEVANCE AND APPEAL SYSTEM

Submit the following consistent with the requirements of EXHIBIT A15: MEMBER GRIEVANCE AND APPEAL SYSTEM.

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.

14. ENROLLMENTS

Submit the following consistent with the requirements of EXHIBIT A16: ENROLLMENTS AND DISENROLLMENTS.

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.

15. MARKETING

Submit the following consistent with the requirements of EXHIBIT A17: MARKETING.

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.

16. CONFIDENTIALITY OF MEMBER INFORMATION

Submit the following consistent with the requirements of SECTION 23. CONFIDENTIALITY OF MEMBER INFORMATION:

1. Submit policies addressing Member's rights to confidentiality of medical/dental information. Include procedures for release of medical/dental information.

EXHIBIT A1.1: IMPLEMENTATION PLAN DELIVERABLES

Plan Name _____

All implementation deliverables are due 30 days after contract effective date and prior to contract operations. See EXHIBIT A1: IMPLEMENTATION PLAN, Provision 1 thru 16, for list and details of individual deliverables.

Deliverable	Provision	Date Submitted	Completed
Conflict of Interest documentation for employees	Exhibit A2, SECTION 3. CONFLICT OF INTEREST – CURRENT AND FORMER STATE EMPLOYEES		
Organization chart	Exhibit A1, SECTION 1. ORGANIZATION AND ADMINISTRATION OF PLAN, Subsection 2		
Knox Keene license exhibits and forms	Exhibit A2, SECTION 1. LEGAL CAPACITY		
Audited annual financial reports	Exhibit A3, SECTION 3. INDEPENDENT FINANCIAL AUDIT REPORTS		
Quarterly financial statement issued prior to contract	Exhibit A3, SECTION 2. CONTRACTOR'S FINANCIAL REPORTING OBLIGATIONS Subsection 3		
Knox Keene financial exhibits HH-1, HH-2, projected Medi-Cal enrollment/ month	Exhibit A1, SECTION 2. FINANCIAL INFORMATION, Subsection 3		
Knox Keene financial exhibits HH-6	Exhibit A1, SECTION 2. FINANCIAL INFORMATION,		

	Subsection 4		
Knox Keene exhibits II-1, II-2 and II-3	Exhibit A1, SECTION 2. FINANCIAL INFORMATION, Subsection 6		
Subcontractors admin and financial capacity to provide at risk services	Exhibit A3, SECTION 6. FISCAL VIABILITY OF NETWORK PROVIDERS AND SUBCONTRACTORS		
Financial policy for budgeting and operations forecasting.	Exhibit A3, SECTION 2. CONTRACTOR'S FINANCIAL REPORTING OBLIGATIONS, Subsection 5		
Policy to monitor financial viability for subcontractors	Exhibit A3, SECTION 1. FINANCIAL VIABILITY/ STANDARDS COMPLIANCE , SECTION 6. FISCAL VIABILITY OF NETWORK PROVIDERS AND SUBCONTRACTORS		
Managed Care Organization Baseline Assessment form	Exhibit A1, SECTION 3. MANAGEMENT INFORMATION SYSTEM (MIS)		
Plan for procuring new or modifying MIS system	EXHIBIT A4: MANAGEMENT INFORMATION SYSTEM (MIS)		
Process for encounter data flow	Exhibit A4, SECTION 2. ENCOUNTER DATA SUBMITTAL		
Encounter data test	Exhibit A4, SECTION 1. MANAGEMENT INFORMATION SYSTEM CAPABILITY		

Policy for encounter data submission	Exhibit A4, SECTION 2. ENCOUNTER DATA SUBMITTAL		
Work plan for HIPAA compliance	Exhibit A4, SECTION 5. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)		
Process for data security, backup, disaster	Exhibit A4, SECTION 6. DATA SECURITY AND BACKUP		
Process for MIS subsystems	Exhibit A4, SECTION 1. MANAGEMENT INFORMATION SYSTEM CAPABILITY		
Sample and description of MIS reports	Exhibit A4, SECTION 1. MANAGEMENT INFORMATION SYSTEM CAPABILITY		
Description of QIOHATP	EXHIBIT A5: QUALITY IMPROVEMENT AND ORAL HEALTH ACCESS TRANSFORMATION PROGRAM		
Policy related to delegation of QIOHATP activities	Exhibit A5, SECTION 6. SUBCONTRACTOR QUALITY IMPROVEMENT ACTIVITIES, SECTION 7. QIOHATP POLICIES AND PROCEDURES		
Boilerplate subcontract language of QIOHATP functions and responsibilities.	Exhibit A5, SECTION 4. QUALITY IMPROVEMENT AND ORAL HEALTH ACCESS COMMITTEE (QIOHEC),		

	SECTION 6. SUBCONTRACTOR QUALITY IMPROVEMENT ACTIVITIES, SECTION 9. QUALITY IMPROVEMENT AND ORAL HEALTH ACCESS ANNUAL PLAN, SECTION 10. EXTERNAL QUALITY REVIEW REQUIREMENTS, SECTION 12. SITE REVIEW		
Policy to address Contractor requirements	Exhibit A5, SECTION 6. SUBCONTRACTOR QUALITY IMPROVEMENT ACTIVITIES, SECTION 7. QIOHATP POLICIES AND PROCEDURES		
Policy for Primary Care Dentist (PCD) site reviews	Exhibit A5, SECTION 12. SITE REVIEW		
List of site reviews prior to operation	Exhibit A5, SECTION 12. SITE REVIEW		
Aggregate results of site review	Exhibit A5, SECTION 12. SITE REVIEW		
Policy for provider credentialing and revalidation	Exhibit A5, SECTION 14. CREDENTIALING AND REVALIDATION		
Policy for disciplinary actions	Exhibit A5, SECTION 14. CREDENTIALING AND REVALIDATION		
Processes of Utilization Management program	Exhibit A7, SECTION 1. UTILIZATION MANAGEMENT (UM) PROGRAM		

Policy for evaluating UM activities for compliance	Exhibit A7, SECTION 1. UTILIZATION MANAGEMENT (UM) PROGRAM		
Complete provider network	Exhibit A8, SECTION 1. NETWORK CAPACITY		
Policy for monitoring provider to patient ratios	Exhibit A8, SECTION 3. PROVIDER TO MEMBER RATIOS		
Policy for providing emergency services	Exhibit A8, SECTION 4. EMERGENCY SERVICES		
Complete list of specialists	Exhibit A8, SECTION 5. SPECIALISTS		
Policy for reimbursement of FQHC, RHC and IHCP	Exhibit A8, SECTION 13. SUBCONTRACTS WITH FEDERALLY QUALIFIED HEALTH CENTERS, RURAL HEALTH CLINICS AND INDIAN HEALTH CARE PROVIDERS (FQHC/RHC/ IHCP)		
GeoAccess report of provider networks	Exhibit A8, SECTION 8. PROVIDER NETWORK REPORTS		
Report of all subcontracting provider groups	Exhibit A8, SECTION 9. PLAN PROVIDER NETWORK		
Analysis of provider network meeting ethnic, cultural and linguistic needs of Members	Exhibit A8, SECTION 10. ETHNIC AND CULTURAL COMPOSITION		
All boilerplate subcontracts	Exhibit A8, SECTION 11. NETWORK PROVIDER AGREEMENTS AND SUBCONTRACTOR AGREEMENTS		

Policy for provider appeals	Exhibit A9, SECTION 2. PROVIDER APPEALS		
Policy for payment of non-contracting providers	Exhibit A9, SECTION 3. NON-CONTRACTING, NON-EMERGENCY PROVIDER COMMUNICATION		
Provider Manual	Exhibit A9, SECTION 4. PROVIDER MANUAL		
Provider Incentive Plans	Exhibit A10, SECTION 3. PROVIDER INCENTIVE PLAN		
Policy for payment of claims	Exhibit A10, SECTION 5. CLAIMS PROCESSING		
Excerpt from Provider Manual describing prohibition of claim or demand for services	Exhibit A10, SECTION 6. PROHIBITED CLAIMS AND PAYMENTS		
FQHC, RHC and Indian Health Service subcontracts	Exhibit A10, SECTION 7. FEDERALLY QUALIFIED HEALTH CENTERS (FQHC), RURAL HEALTH CLINICS (RHC), AND INDIAN HEALTH CARE PROVIDERS (IHCP)		
Schedule of per diem rate and/or FFS rate for each provider type	Exhibit A10, SECTION 7. FEDERALLY QUALIFIED HEALTH CENTERS (FQHC), RURAL HEALTH CLINICS (RHC), AND INDIAN HEALTH CARE PROVIDERS (IHCP)		
Policy for access and availability standards	Exhibit A11, SECTION 2. ACCESS REQUIREMENTS, SECTION 3. ACCESS STANDARDS		

Policy for referrals	Exhibit A11, SECTION 2. ACCESS REQUIREMENTS		
Policy for emergency access to services	Exhibit A11, SECTION 4. CHANGES IN AVAILABILITY OR LOCATION OF COVERED SERVICES		
Policy for disabled Members	Exhibit A11, SECTION 5. ACCESS FOR MEMBER WITH DISABILITIES AND LANGUAGE AND COMMUNICATION ASSISTANCE		
Policy for compliance with Civil Rights Act of 1964	Exhibit A11, SECTION 6. POPULATION HEALTH MANAGEMENT (PHM) PROGRAM REQUIREMENTS		
Policy for 24-hour interpreter services	Exhibit A11, SECTION 7. CULTURAL AND LINGUISTIC PROGRAM		
Policy for disaster recovery	Exhibit A11, SECTION 11. HEALTHCARE SURGE EVENTS		
Policy for EPSDT services	Exhibit A12, SECTION 3. SERVICES FOR MEMBERS UNDER 21 YEARS OF AGE		
Policy for health education system	Exhibit A12, SECTION 4. SERVICES FOR ALL MEMBERS		
Policy for coordination of care	Exhibit A13, EXHIBIT A13: CASE MANAGEMENT AND COORDINATION OF CARE		

Policy that addresses Members' rights and responsibilities	Exhibit A14, SECTION 1. MEMBERS RIGHTS AND RESPONSIBILITIES		
Policy for training of Members services staff	Exhibit A14, SECTION 2. MEMBER SERVICES STAFF		
Policy to provide information to Members	Exhibit A14, SECTION 4. WRITTEN MEMBER INFORMATION		
Member identification card and Member services guide	Exhibit A14, SECTION 4. WRITTEN MEMBER INFORMATION		
Policy regarding Member selection of PCD	Exhibit A14, SECTION 6. PRIMARY CARE DENTIST SELECTION		
Policy regarding Member assignment to PCD	Exhibit A14, SECTION 7. PRIMARY CARE DENTIST ASSIGNMENT		
Policy notifying PCD of Member assignment or selection	Exhibit A14, SECTION 7. PRIMARY CARE DENTIST ASSIGNMENT		
Policy notifying Members of action on prior authorization	Exhibit A14, SECTION 8. DENIAL, DEFERRAL, OR MODIFICATION OF PRIOR AUTHORIZATION REQUESTS		
Policy for Member grievance and appeal system	Exhibit A15, SECTION 1. MEMBER GRIEVANCE AND APPEAL SYSTEM, SECTION 2. GRIEVANCES, SECTION 3. APPEALS		
Policy for oversight of Member	Exhibit A15, SECTION 7.		

grievance and appeal system	CONTENTS OF THE NOTICE, SECTION 11. GRIEVANCE AND APPEAL SYSTEM OVERSIGHT		
Policy regarding accurate information on providers	Exhibit A16, SECTION 1. ENROLLMENT PROGRAM		
Policy for utilization of enrollment data from DHCS	Exhibit A16, SECTION 2. ENROLLMENT		
Policy for Member disenrollment	Exhibit A16, SECTION 4. DISENROLLMENT		
Marketing plan	Exhibit A17, SECTION 3. MARKETING PLAN		
Boilerplate request form to obtain DHCS marketing approval	Exhibit A17, SECTION 2. DHCS APPROVAL		
Policy addressing Members right to confidentiality of medical/dental information	Exhibit E, SECTION 23. CONFIDENTIALITY OF MEMBER INFORMATION		

EXHIBIT A2: ORGANIZATION AND ADMINISTRATION OF THE PLAN

1. LEGAL CAPACITY

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

2. 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 five percent (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:

    a. For any person (individual corporation) with an ownership or control interest in the Contractor or its Subcontractors:

        1. 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.

        2. The date of birth and Social Security Number (in the case of an individual).

    b. Other tax identification number of any corporation with:

        1. An ownership or control interest in the Contractor.

2. Any Subcontractor in which the Contractor has an interest of five percent (5%) or more.

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 Title 42 Code of Federal Regulations (CFR) § 455.104(b) at the following times:

1. When the Contractor submits a proposal in accordance with DHCS' procurement process.

2. When the Contractor executes a contract with DHCS.

3. When DHCS renews or extends its contract with the Contractor.

4. 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 (Disclosure by providers; Information on persons convicted of crimes) and 42 CFR 438.610 (Prohibited Affiliations):

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 five percent (5%) 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. 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.

3. CONFLICT OF INTEREST – CURRENT AND FORMER STATE EMPLOYEES

1. This Contract shall be governed by the Conflict of Interest provisions of Title 22 CCR Sections 53874 and 53600, and 42 CFR 438. 3(f)(2).

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. For purposes of this subsection (C) only, employee in the State civil service is defined to be any person legally

holding a permanent appointed or intermittent position in the State civil service.

4. CONTRACT PERFORMANCE

Contractor shall maintain the organization and staffing for implementing and operating the Contract in accordance with Title 28 CCR Section 1300.67.3, Title 22 CCR Sections 53900, 53800, 53851 and 53857. Contractor shall ensure:

1. The organization has an accountable governing body.

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

3. If the Contractor is a subsidiary organization, the attestation of the parent organization that this Contract will be a high priority to the parent organization. The parent organization is committed to supplying any necessary resources to assure full performance of the Contract.

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

5. Written procedures for the conduct of the business of the plan, including the provision of health care services, in order to provide effective controls.

5. DENTAL CLINICAL DECISIONS

Contractor shall ensure that dental clinical decisions, including those by Subcontractors, Network Providers, and other rendering Providers, are not unduly influenced by fiscal and administrative management.

6. 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 Medicare, 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.

c. Ensuring that the dental care provided meets the standards for acceptable dental care.

d. Ensuring that dental protocols and rules of conduct for plan dental personnel are followed.

e. Developing and implementing dental policy.

f. Resolving grievances related to dental quality of care.

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

h. Actively participate in the functioning of the Contractor's grievance procedures as specified in EXHIBIT A15: MEMBER GRIEVANCE AND APPEAL SYSTEM.

7. CHIEF ORAL HEALTH ACCESS OFFICER

Contractor must maintain a full-time chief oral health access officer who has the necessary qualifications or training at the time of hire or within one year of hire to meet the requirements of the position. The chief oral health access officer responsibilities must include, but should not be limited to, the following:

1. Provide leadership in the design and implementation of Contractor's strategies and programs to ensure Oral Health Access is prioritized and addressed;

2. Ensure all Contractor policy and procedures consider Health Disparities and are designed to promote Oral Health Access where possible, including but not limited to:

    a. Marketing strategy;

    b. Medical and other health services policies;

    c. Member and provider outreach;

    d. Community Advisory Committee;

    e. Quality Improvement activities, including delivery system reforms;

    f. Grievance and Appeals; and

g. Utilization Management

3. Develop and implement policies and procedures aimed at improving Oral Health Access and reducing Oral Health Disparities;

4. Engage and collaborate with Contractor staff, Subcontractors, Network Providers, and entities included, but not limited to local community-based organizations, local oral health programs within the service area, child welfare systems and Members in Oral Health Access efforts and initiatives;

5. Implement strategies designed to identify and address root causes of Health Disparities, which includes but is not limited to systemic racism, Social Drivers of Oral Health, and infrastructure barriers;

6. Develop targeted interventions designed to eliminate Oral Health Disparities;

7. Develop quantifiable metrics that can track and evaluate the results of the targeted interventions designed to eliminate Oral Health Disparities;

8. Ensure all Contractor, Subcontractor and Network Provider staff receive mandatory diversity, equity and inclusion training (sensitivity, diversity, communication skills, and cultural competency training) as specified in SECTION 7.4. DIVERSITY, EQUITY AND INCLUSION TRAINING. This includes, but is not limited to:

    a. Reviewing training materials to ensure the materials are up-to-date with current standards of practice; and

    b. Maintaining records of training completion.

8. DENTAL DIRECTOR CHANGES

Contractor must report to DHCS Contract Manager any changes in the status of the executive-level personnel including, but not limited to the Chief Executive Officer, Chief Financial Officer, Chief Operations Officer, the Chief Medical Director, the Chief Oral Health Access Officer, and the Compliance Officer and Government Relations persons within ten calendar days. Contractor must also report to DHCS Contract Manager any changes in the status of the executive-level personnel for Subcontractors including, but not limited to the Chief Executive Officer, Chief Financial Officer, Chief Operations Officer, the Medical Director, the Chief Oral Health Access Officer, and the Compliance Officer and Government Relations persons within 20 calendar days.

9. ADMINISTRATIVE DUTIES/RESPONSIBILITIES

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

1. Member and Enrollment reporting systems as specified in EXHIBIT A4: MANAGEMENT INFORMATION SYSTEM (MIS); EXHIBIT A14: MEMBER SERVICES AND BENEFICIARY SUPPORT; and EXHIBIT A15: MEMBER GRIEVANCE AND APPEAL SYSTEM.

2. A Member grievance and appeal procedure, as specified in EXHIBIT A15: MEMBER GRIEVANCE AND APPEAL SYSTEM.

3. Data reporting capabilities sufficient to provide necessary and timely reports to DHCS, as required by EXHIBIT A4: MANAGEMENT INFORMATION SYSTEM (MIS).

4. 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 A3: FINANCIAL INFORMATION.

5. Claims processing capabilities as described in SECTION 5. CLAIMS PROCESSING.

6. A system for providing Members dental health education services and clinical preventive services consistent with SECTION 4. SERVICES FOR ALL MEMBERS.

7. A provider appeal procedure.

8. A Quality Improvement and Oral Health Access Transformation Program consistent with EXHIBIT A5: QUALITY IMPROVEMENT AND ORAL HEALTH ACCESS TRANSFORMATION PROGRAM.

9. Participate in all meetings with DHCS.

10. Acknowledge or respond to all correspondence from DHCS in writing.

11. Maintain data and information exchange capabilities as needed to meet Contractor’s obligation under the Contract and to support DHCS’ administration of the Medi-Cal program through data sharing with other trading partners. This includes, but is not limited to, encounter data, dental record information, Network Provider and Provider information, Member demographics, and case notes;

Maintain Quality Improvement activities and Population Health Management activities. as described in EXHIBIT A5: QUALITY IMPROVEMENT AND ORAL HEALTH ACCESS TRANSFORMATION PROGRAM;

12. Maintain a Utilization Management (UM) program, as described in EXHIBIT A7: UTILIZATION MANAGEMENT;

13. Maintain network adequacy as described in EXHIBIT A8: PROVIDER NETWORK and EXHIBIT A11: ACCESS AND AVAILABILITY;

14. Comply with requirements, as described in EXHIBIT A9: PROVIDER RELATIONS;

15. Form a Community Advisory Committee (CAC) and meet expectations, as described in EXHIBIT A11: ACCESS AND AVAILABILITY and is an active participant in quality, oral health access, disparities, population health, children services, and other ongoing plan functions;

16. Provide or arrange for all Medically Necessary Covered Services for Members, as described in EXHIBIT A12: SCOPE OF SERVICES;

17. Provide Care Coordination, including but not limited to all Medically Necessary services delivered both within and outside Contractor's Network, as described in EXHIBIT A11: ACCESS AND AVAILABILITY and SECTION 11. CASE MANAGEMENT AND COORDINATION OF CARE;

18. Maintain Member Grievance procedures, as specified in EXHIBIT A15: MEMBER GRIEVANCE AND APPEAL SYSTEM;

19. Cooperate with the DHCS Enrollment program, as described in EXHIBIT A16: ENROLLMENTS AND DISENROLLMENTS;

20. Comply with the requirements, as described in EXHIBIT A14: MEMBER SERVICES AND BENEFICIARY SUPPORT;

10. MEMBER REPRESENTATION

Contractor shall ensure that Medi-Cal Members are included and participate in establishing public policy within the Contractor's advisory committee or other similar committee or group.

11. DIVERSITY, EQUITY AND INCLUSION TRAINING

Contractor must ensure that all staff who interact with, or may potentially interact with, Members and any

other staff deemed appropriate by Contractor or DHCS, shall receive annual sensitivity, diversity, communication skills, and cultural competency training as specified in EXHIBIT A11: ACCESS AND AVAILABILITY.

EXHIBIT A3: FINANCIAL INFORMATION

1. FINANCIAL VIABILITY/STANDARDS COMPLIANCE

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

1. Tangible Net Equity (TNE).

   The Contractor shall comply, at all times, with the TNE requirements in accordance with Title 28 California Code of Regulations (CCR) Section 1300.76.

2. Administrative Costs.

   Contractor's Administrative Costs must comply with the standards set forth in 22 CCR section 53864(b).

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 and Title 22 CCR Section 53851, 53863, and 53864.

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

   a. Contractor must maintain a Working Capital Ratio of current assets to current liabilities of at least 1:1 in accordance with Health & Safety Code (H&S) section 1375.4

   b. Contractor must demonstrate to DHCS that Contractor is meeting financial obligations on a timely basis and has been doing so for at least the preceding two years; or

   c. Contractor must 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.

5. In the event DHCS finds Contractor non-compliant with any of the elements or obligations set forth in this Provision, DHCS may impose a Corrective Action plan or sanctions in accordance with EXHIBIT E: ADDITIONAL PROVISIONS and W&I Code section 14197.7. See SECTION 18. SANCTIONS.

2. CONTRACTOR'S FINANCIAL REPORTING OBLIGATIONS

1. Form and Standards for Financial Reporting
   Contractor must provide financial information and reports, including but not limited to Financial Statements, to DHCS in the form and manner specified by DHCS. Unless otherwise specified by DHCS, Contractor must prepare all financial information requested by DHCS in accordance with Generally Accepted Accounting Principles (GAAP) and the 1989 HMO Financial Report of Affairs and Conditions format. Any Department of Managed Health Care (DMHC) required reports must be prepared in DMHC-required financial reporting format, and in accordance with 28 CCR section 1300.84. Information submitted by Contractor must be based on current operations. Where appropriate, reference has been made to the Knox Keene Act (KKA) rules found under 28 CCR sections 1300.51 *et seq*.
   Unless otherwise specified by DHCS, all Financial Statements must include, at a minimum, the following reports/schedules unless explicitly excluded in this Attachment:
   a. Jurat;
   b. Report 1A and 1B: Balance Sheet;
   c. Report 2: Statement of Contract Revenue, Expenses, and Net Worth;
   d. Statement of Cash Flow, prepared in accordance with Financial Accounting Standards Board Statement Number 95 in lieu of Report 3: Statement of Changes in Financial Position for GAAP compliance;
   e. Report 4: Enrollment and Utilization Table;
   f. Schedule G: Unpaid Claims Analysis;
   g. Appropriate footnote disclosures in accordance with GAAP; and
   h. Schedule H: Aging of All Claims.

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

i. Report 2: Statement of Contract Revenue and Expenses; and

j. Report 4: Enrollment and Utilization Table by County/Rating Region.

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

Contactor shall submit the Medi-Cal line of business Financial Statements within the same timeframe as indicated for each required Financial Statement.

2. Monthly Reporting Obligations

Contractor must submit to DHCS, no later than thirty (30) calendar days after the close of Contractor's fiscal month, an exact copy of any reports required be filed in accordance with 28 CCR section 1300.84.3.

3. Quarterly Reporting Obligations

Contractor must submit to DHCS, no later than forty-five (45) calendar days after the close of Contractor's fiscal quarter, an exact copy of any reports required to be filed in accordance with 28 CCR section 1300.84.2.

4. Annual Reporting Obligations

Contractor must prepare and submit to DHCS, no later than one hundred twenty (120) calendar days after the close of Contractor's Fiscal Year, an exact copy of any reports required to be filed in accordance with 28 CCR section 1300.84.06.

5. Annual Forecasts

Contractor must submit to DHCS annual forecasts of Contractor's next Fiscal Year no later than sixty (60) calendar days prior to the beginning each Fiscal Year. Contractor's annual forecast must be prepared using DMHC required financial reporting forms and must include, at a minimum, the following reports/schedules:

a. Report 2: Statement of Contract Revenue and Expenses (Medi-Cal line-of-business);
b. Report 4: Enrollment and Utilization Table by County/Rating Region (Medi-Cal line-of-business);
c. TNE (All lines of business); and

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

6. Publication of Financial Reports

   Financial Reports submitted in accordance with this Section B are public records and may be made public by DHCS.

3. INDEPENDENT FINANCIAL AUDIT REPORTS

Contractor must ensure that an annual audit is performed by an independent Certified Public Accountant in accordance with 42 CFR section 438.3(m) and W&I Code section 14459. Except as indicated in Paragraph 2 of this Provision, a copy of the resulting independent financial audit report must be submitted to DHCS no later than one hundred twenty (120) calendar days after the close of Contractor's Fiscal Year.

When the delivery of care or other services is dependent upon Affiliates of Contractor, Contractor must submit combined annual Financial Statements that reflect the financial position of Contractor's overall health care delivery system in accordance with 28 CCR section 1300.84(c). Such combined annual Financial Statements must be presented in a form that clearly shows the financial position of Contractor separately from the combined totals set forth in the combined Financial Statements. Intra-entity or related party transactions and profits must be eliminated if consolidated Financial Statements are prepared and submitted by Contractor. Contractor also must submit to DHCS any financial audit conducted by DMHC pursuant to H&S Code section 1382 within thirty (30) calendar days of Contractor's receipt thereof.

In the event that Contractor's retained independent Certified Public Accountant determines that preparation of combined annual Financial Statements is inappropriate or impracticable under the circumstances, separate certified Financial Statements must be prepared for each entity involved in the delivery of health care services by Contractor, and such separate, annual Financial Statements must be submitted to DHCS, along with the following:

1. Contractor must provide the independent Certified Public Accountant's written statement of the reasons for not preparing combined Financial Statements;

2. Contractor must provide supplemental schedules that clearly reflect all intra-entity or related party transactions and eliminations necessary to enable DHCS to analyze the overall financial position of the Contractor's entire health care delivery system. If Contractor is a public entity or a political subdivision of the State and a county grand jury conducts Contractor's financial audits, Contractor must submit its Financial Statements within one hundred eighty (180) calendar days after the close of Contractor's Fiscal Year in accordance with H&S Code section 1384;

3. Contractor must authorize its independent Certified Public 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;

4. Contractor must submit to DHCS all financial reports relevant to Affiliates as specified in 28 CCR section 1300.84(c); and Contractor must submit to DHCS copies of any financial reports submitted to any other public or private organization within ten (10) calendar days of submission to such other public or private organization.

4. COOPERATION WITH DHCS' FINANCIAL AUDITS

DHCS must conduct, or contract for the conduct of, periodic audits of the accuracy, truthfulness, and completeness of the financial data submitted by, or on behalf of, Contractor in accordance with 42 CFR section 438.602(e). Contractor must cooperate with these audits and provide all information and materials requested by DHCS, or its contracted auditor, for this purpose.

5. MEDICAL LOSS RATIO (MLR)

Contractor must annually report a Medical Loss Ratio (MLR) as described in this Provision and in accordance with 42 CFR section 438.8. Contractor must impose equivalent MLR reporting and remittance requirements on Fully Delegated Subcontractors, Partially Delegated Subcontractors, Downstream Fully Delegated Subcontractors, and Downstream Partially Delegated Subcontractors.

1. Contractor must calculate and report a MLR as stated in 42 CFR sections 438.8 and 438.604(a)(3) in a form and manner specified by DHCS.

    a. Contractor must ensure that revenues, expenditures, and other amounts are appropriately identified and classified including by distinguishing which amounts were actually paid for benefits, or activities that improve health care quality, and which amounts were actually paid for administrative services, taxes, or other activities in accordance with the Centers for Medicare & Medicaid Services (CMS) Informational Bulletin published May 15, 2019, with the subject "Medical Loss Ratio Requirements Related to Third-Party Vendors."

    b. Contractor must, in compliance with 42 CFR 438.230(c)(1) Contractor must, in compliance with 42 CFR 438.230(c)(1) and California Advancing and Innovating Medi-Cal (CalAIM) Terms and Conditions, in particular Paragraph 11 of the 1915 (b) Waiver STCs, require all applicable Subcontractors and Downstream Subcontractors, to comply with the MLR reporting responsibilities in this Section, including the requirement to distinguish which amounts are actually paid for benefits, or activities that improve health care quality, and which amounts were actually paid for administrative services, taxes, or other activities in accordance with the CMS Informational Bulletin published May 15, 2019 with the subject "Medical Loss Ratio Requirements Related to Third-Party Vendors." Payments to a Subcontractor or Downstream Subcontractor that are not the amount actually paid to a

Provider or supplier for furnishing Covered Services must not be included in incurred claims.

2. The MLR experienced by Contractor in a MLR Reporting Year is the ratio of the numerator, as stated in Paragraph 5 of this Section, to the denominator, as stated in Paragraph 64 of this Section. A MLR may be increased by a credibility adjustment in accordance with Paragraph 8 of this Provision.

3. DHCS utilizes a materiality threshold for determining whether Fully Delegated Subcontractors, Partially Delegated Subcontractors, Downstream Fully Delegated Subcontractors, and Downstream Partially Delegated Subcontractors are subject to the reporting and remittance requirements. The materiality threshold may be based on one or more of the following:

    a. Annual Medi-Cal revenue;
    b. The Medi-Cal lives for which risk is delegated;
    c. The scope of Medi-Cal services for which risk is delegated; or
    d. Other factors.

4. Subcontractor and Downstream Subcontractor arrangements that fall below the materiality threshold for an MLR reporting year, as specified by DHCS, are not subject to MLR reporting for that MLR reporting year. DHCS reserves the right to reestablish the threshold annually, may require reporting by certain Subcontractors and Downstream Subcontractors regardless of materiality, and will communicate details of the materiality threshold and subsequent updates and/or changes through APLs or other instruction.

5. The numerator of Contractor's, Subcontractors', and Downstream Subcontractors' MLR for a MLR Reporting Year is the sum of Contractor's, Subcontractors', and Downstream Subcontractors' incurred claims, expenditures for activities that improve health care quality, and Fraud prevention activities.

    a. Contractor's, Subcontractors', and Downstream Subcontractors' Incurred Claims

        i. Incurred claims must include the following:

            1. Direct claims that Contractor, Subcontractors, and Downstream Subcontractors, as applicable, paid to Providers, including under capitated contracts with Network Providers, for Covered Services or supplies under this Contract, a Subcontractor Agreement, or a Downstream Subcontractor Agreement, as applicable, and meeting the requirements of 42 CFR section 438.3(e);

2. Unpaid claims liabilities for the MLR Reporting Year, including claims reported that are in the process of being adjusted or claims incurred but not reported;

3. Withholds from payments made to Network Providers;

4. Claims that are recoverable for anticipated coordination of benefits;

5. Claims payments recoveries received due to subrogation;

6. Incurred but not reported claims based on past experience, and modified to reflect current conditions, such as changes in exposure or claim frequency or severity;

7. Changes in other claims-related reserves; and

8. Reserves for contingent benefits and the medical claim portion of lawsuits.

ii. Amounts that must be deducted from incurred claims include the following:

1. Identified unrecovered Overpayments and Overpayment recoveries received from Network Providers; and

2. Prescription drug rebates received and accrued.

3. Amounts received as remittances from Subcontractors and Downstream Subcontractors, as applicable, in accordance with Paragraph 13 of this provision and Exhibit B of this Contract. Subcontractors and Downstream Subcontractors must deduct amounts received as remittances from their downstream entities. The contracts between all downstream entities in Contractor's delegation arrangement must include this reference.

iii. Expenditures that must be included in incurred claims include the following:

1. The amount of incentive and bonus payments made, or expected to be made, to Network Providers that are tied to clearly-defined, objectively measurable, and well-documented clinical or quality improvement standards that apply to providers; and

2. The amount of claims payments recovered through Fraud reduction efforts, not to exceed the amount of Fraud reduction expenses. The amount of Fraud reduction expenses must not include activities specified in Paragraph 5(b)(3) of this Provision.

3. The amount of payments made to providers under State directed payments described in 42 CFR section 438.6(c).

iv. Amounts that must either be included in or deducted from incurred claims include, respectively, net payments or receipts related to solvency funds mandated by DHCS.

v. The following amounts must be excluded from incurred claims.

1. Non-Claims Costs, which include (1) the amounts paid to third-party vendors for secondary network savings; (2) amounts paid to third-party vendors for network development, administrative fees, claims processing, and UM; (3) amounts paid for professional or administrative services, including amounts paid to a Provider, that do not represent compensation or reimbursement for California Medicaid State Plan services or services defined in 42 CFR section 438.3(e) and provided to Members; and (4) amounts paid for fines and penalties assessed by regulatory authorities; and

2. Amounts paid to DHCS as remittances in accordance with Paragraph 13 of this provision and Exhibit B of this Contract; and

3. Amounts paid to upstream entities as remittance in accordance with Paragraph 16 of this Subsection. The contracts between all downstream entities in Contractor's delegation arrangement must include this reference; and

4. Amounts paid to Network Providers under 42 CFR section 438.6(d).

vi. Incurred claims paid by an entity that is later assumed by another entity must be reported by the assuming entity for the entire MLR Reporting Year and no incurred claims for that MLR Reporting Year may be reported by the ceding entity.

b. Activities that improve health care quality must be in one of the following categories:

i. Contractor's, Subcontractors', and Downstream Subcontractors', as applicable, activity that meets the requirements of 45 CFR section 158.150 (a) and (b) and is not excluded under 45 CFR section 158.150(c);

ii. Contractor's, Subcontractors', and Downstream Subcontractors', as applicable, activity related to any External Quality Review-related activity as described in 42 CFR sections 438.358(b) and (c); or

iii. Any Contractor's, Subcontractors', and Downstream Subcontractors', as applicable, expenditure that is related to Health Information Technology (HIT) and meaningful use, meets the requirements placed on issuers set forth in 45 CFR section 158.151, and is not considered incurred claims, as defined in this Subsection.

c. Contractor's, Subcontractors', and Downstream Subcontractors', as applicable, expenditures on activities related to Fraud prevention as described in 45 CFR Part 158, and not including expenses for Fraud reduction efforts as stated in Paragraph 5.a.3.ii 3.a).3)ii. of this Provision Subsection.

6. The denominator of Contractor's, Subcontractors', and Downstream Subcontractors' MLR for a MLR Reporting Year must equal the adjusted premium revenue for Contractor's, Subcontractors' and Downstream Subcontractors' Medi-Cal line of business. The adjusted premium revenue is Contractor's, Subcontractors', and Downstream Subcontractors premium revenue minus Contractor's, Subcontractors', and Downstream Subcontractors' federal, State, and local taxes and licensing and regulatory fees, and is aggregated in accordance with this Subsection.

a. Premium revenue includes the following for the MLR Reporting Year:

i. Capitation Payments, developed in accordance with 42 CFR section 438.4, and excluding payments made per 42 CFR section 438.6(d);

ii. One-time payments for Member life events as specified in this Contract;

iii. Other payments to Contractor approved under 42 CFR section 438.6(b)(3);

iv. All changes to unearned premium reserves; and

v. Net payments or receipts related to risk sharing mechanisms developed in

accordance with 42 CFR sections 438.5 or 438.6.

vi. Payments to Contractor for expenditures under State directed payments described in 42 CFR section 438.6(c).

vii. Notwithstanding (a)-(c), for Subcontractors and Downstream Subcontractors, premium revenue includes all payments received pursuant to a Subcontractor Agreement or Downstream Subcontractor Agreement, excluding payments received in accordance with 42 CFR section 438.6(d).

b. Taxes, licensing, and regulatory fees for the MLR Reporting Year must include:

i. Statutory assessments to defray the operating expenses of any State or federal department;

ii. Examination fees in lieu of premium taxes as specified by State law;

iii. Federal taxes and assessments allocated to Contractor, Subcontractors, or Downstream Subcontractors, as applicable, excluding federal income taxes on investment income, capital gains, and federal employment taxes;

iv. State and local taxes and assessments including:

1. Any industry-wide or subset assessments, other than surcharges on specific claims, paid to the State or a locality directly.

2. Guaranty fund assessments.

3. Assessments of State or local industrial boards or other boards for operating expenses, or for benefits to sick employed persons in connection with disability benefit laws or similar taxes levied by the State.

4. State or local income, excise, and business taxes, other than premium taxes and State employment and similar taxes and assessments.

5. State or local premium taxes, plus State or local taxes based on reserves, if in lieu of premium taxes.

v. Payments made by Contractor, Subcontractors, and Downstream Subcontractors, as applicable, that are otherwise exempt from federal income taxes, for community benefit expenditures as defined in 45 CFR section 158.162(c), limited to the higher of either:

1. Three percent (3%) of earned premium; or

2. The highest premium tax rate in the State, multiplied by Contractor's, Subcontractors', or Downstream Subcontractors', as applicable, earned premium in the State.

c. If Contractor, or any Subcontractor or Downstream Subcontractor, is later assumed by another entity that becomes the new Contractor, Subcontractor, or Downstream Subcontractor under this Contract, a Subcontractor Agreement, or a Downstream Subcontractor Agreement, the new Contractor, Subcontractor, or Downstream Subcontractors must report the total amount of the denominator for the entire MLR Reporting Year, and no amount under this Paragraph for that year may be reported by the ceding Contractor, Subcontractor, or Downstream Subcontractor.

7. In the allocation of expense, Contractor, Subcontractors, and Downstream Subcontractors must include each expense 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. Contractor, Subcontractors, and Downstream Subcontractors must use the following methods to allocate expenses:

a. Allocation to each category must be based on a Generally Accepted Accounting Principles (GAAP) method that is expected to yield the most accurate results;

b. Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the contract incurring the expense; and

c. Expenses that relate solely to the operation of a reporting entity, such as staff 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.

8. Contractor, Subcontractors, and Downstream Subcontractors may add a credibility adjustment to a calculated MLR if the MLR Reporting Year experience is partially credible to account for a difference between the actual and target MLRs that may be due to random statistical variation. The credibility adjustment is added to the reported MLR calculation before calculating any remittance.

    a. Contractor, Subcontractors, and Downstream Subcontractors may not add a credibility adjustment to a calculated MLR if the MLR Reporting Year experience is Fully Credible.

    b. If Contractor's, Subcontractors, or Downstream Subcontractor's experience is Non-Credible, it is presumed to meet or exceed the MLR calculation standards in this Subsection.

    c. Non-credible and partially-credible Contractors, Subcontractors, and Downstream Subcontractors that meet the materiality threshold must submit an MLR report regardless of credibility.

    d. Contractor, Subcontractors, and Downstream Subcontractors must fulfill these requirements by using the base credibility factors that CMS publishes annually in accordance with 42 CFR section 438.8(h)(4).

    e. Contractor must submit a MLR report regardless of credibility. DHCS may require MLR reporting by certain Subcontractors or Downstream Subcontractors regardless of credibility.

9. Contractor, Subcontractors, and Downstream Subcontractors must aggregate data by Potential Member groups as defined in this Contract, or as otherwise directed by DHCS. This may require separate reporting and MLR calculations for specific populations.

10. Contractor must report its MLR to DHCS by county or rating region. Subcontractors and Downstream Subcontractors must report their MLR at the Subcontractor or Downstream Subcontractor arrangement level, by county or rating region, to their upstream entity.

11. MLR Reporting Requirements.

    a. Contractor, Subcontractors, and Downstream Subcontractors must submit a report to DHCS that includes at least the following information for each MLR Reporting Year:

i. Total incurred claims;

ii. Expenditures on quality improvement activities;

iii. Expenditures related to activities compliant with 42 CFR sections 438.608(a)(1) - (5), (7), (8), and (b);

iv. Non-Claims Costs;

v. Premium revenue;

vi. Taxes, licensing, and regulatory fees;

vii. Methodology(ies) for allocation of expenditures, which must include a detailed description of the methods used to allocate expenses, including incurred claims, quality improvement expenses, federal and State taxes and licensing or regulatory fees, and other non-claims costs, as described in 45 CFR section 158.170(b);

viii. Any Credibility Adjustment applied;

ix. The calculated MLR;

x. Any remittance owed to DHCS, if applicable;

xi. A comparison of the information reported with the audited financial report required under 42 CFR section 438.3(m);

xii. A description of the method used to aggregate data; and

xiii. The number of Member months.

b. Contractor must submit this report in a timeframe and manner determined by DHCS, but no longer than twelve (12) months after the end of the MLR Reporting Year.

c. Contractor must require any Subcontractor or other third-party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to Contractor within one hundred eighty (180) calendar days from the end of the MLR Reporting Year, or within thirty (30) calendar days of being requested by Contractor, whichever is sooner, regardless of current contracting limitations, to calculate and validate

the accuracy of MLR reporting.

d. Contractor must require Subcontractors impose reporting requirements equivalent to the information required in 42 CFR section 438.8(k) on Downstream Subcontractors who accept financial risk to perform delegated activities and reporting responsibilities specific for those services they do not directly provide to Members, in accordance with 42 CFR section 438.230(c)(1). Subcontractors must comply with all applicable Medi-Cal laws and regulations, including applicable sub-regulatory guidance and provisions of this Contract, in accordance with 42 CFR section 438.230(c)(2).

e. Contractor, Subcontractors, and Downstream Subcontractors must attest to the accuracy of the MLR calculation in accordance with requirements of this Provision when submitting the MLR report.

f. Contractor must ensure Subcontractor submissions are in accordance with the information required in 42 CFR section 438.8(k). Contractor is expected to review and provide oversight of Subcontractor MLR submissions. Specific expectations include, but are not to be limited to:

    i. Review of each applicable Subcontractor's MLR and reported medical cost per Member per month to identify and investigate outliers;

    ii. Review of reported expenses to ensure medical and non-medical expenses are appropriately accounted for in the MLR calculation;

    iii. Verification that reported expenses align with service volume reported in encounters;

    iv. Verification that reported revenues align with the upstream entities' reported payments;

    v. Review of the reasonableness of methodologies for allocation of expenditures across multiple lines of business;

    vi. Review of the reasonableness of IBNR estimates.

Contractor will impose the aforementioned review and oversight expectations on Subcontractors and Downstream Subcontractors, as applicable, for their downstream entities. The contracts between all downstream entities in Contractor's delegation

arrangement must include a reference to Exhibit A, Attachment III, Subsection 1.2.5.K.4 and 6 (Medical Loss Ratio).

12. Contractor may be excluded from the reporting requirements in this Provision in the first MLR Reporting Year of its operation. Contractor then must comply with these requirements beginning with the next MLR Reporting Year in which it contracts with DHCS, even if the first MLR Reporting Year was not a full twelve (12) months.

13. Consistent with 42 CFR section 438.8(l), Contractor may exempt newly contracted Subcontractors and Downstream Subcontractors from the MLR reporting requirements in the Subcontractor's or Downstream Subcontractor's first MLR reporting year of its operation. Contractor then must require Subcontractors and Downstream Subcontractors to comply with the MLR reporting year requirements in the next reporting year even if the first MLR reporting year did not cover a full 12 months of operation.

    a. Contractors must report any excluded Subcontractors and Downstream Subcontractors to DHCS by the end of the third quarter of that MLR reporting year utilizing DHCS' reporting form.
    b. 2) DHCS retains the discretion to reverse any exemption based on information obtained during the initial review of MLR reporting and/or subsequent State or federal reviews or audits. Contractor must comply, and must require their Subcontractors and Downstream Subcontractors to comply, with any such reversal and submit or amend MLR reporting as needed.

14. In any instance where DHCS makes a retroactive change to the Capitation Payments for a MLR Reporting Year and the MLR report has already been submitted to DHCS, Contractor must re- calculate the MLR for all MLR Reporting Years affected by the change and submit a new report meeting the reporting requirements in this Subsection.

15. Contractor must impose the above retroactive reporting requirements on its Subcontractors and Downstream Subcontractors where DHCS makes a retroactive change to the Capitation Payments for a MLR reporting year and the MLR report has already been submitted to Contractor or upstream Subcontractor. In its sole discretion, DHCS reserves the right to limit MLR re-reporting for Subcontractors and Downstream Subcontractors to no more than one instance and may require re-reporting on an ad hoc basis. Subcontractors and Downstream Subcontractors must not re-report a MLR more than once for any MLR reporting year absent DHCS' review and express permission for any such MLR re-reporting. DHCS has the sole authority and discretion to grant or deny permission to any request for a Subcontractor or

Downstream Subcontractor to re-report more than once for any MLR reporting year. The contracts between all downstream entities in Contractor's delegation arrangement must include this reference.

16. Contractor must, if applicable, provide a remittance for a MLR Reporting Year in accordance with W&I section 14197.2(c)(1) and Exhibit B of this Contract. Contractor must impose equivalent remittance requirements on its Subcontractors and Downstream Subcontractors.

17. In accordance with the CalAIM 1915(b) Waiver STCs, DHCS will work with CMS to effectuate an audit of MLR reports no sooner than the 2028 calendar year. The MLR audit will include the time period covered by the CalAIM 1915(b) Waiver (January 1, 2022 through December 31, 2026).

    a. To allow DHCS and CMS to complete an accurate audit of the MLR reports, Contractors, Subcontractors, and Downstream Subcontractors must maintain all records and documents relating to MLR reports for a minimum of 10 years as described in 42 CFR section 438.3(u).
    b. 2) Pursuant to 42 CFR section 438.3(h), DHCS and its contractor(s) may, at any time, request, inspect, and audit any of Contractor's, Subcontractors', and Downstream Subcontractors' records or documents. Record retention requirements are also referenced in Exhibit E of this Contract.

6. FISCAL VIABILITY OF NETWORK PROVIDERS AND SUBCONTRACTORS

Contractor shall maintain a system to evaluate and monitor the financial viability of Network Providers and Subcontractors that accept financial risk for the provision of Covered Services including, but not limited to, Dental Managed Care Plans, independent Provider associations, medical groups, hospitals, risk-bearing organizations as defined in Title 28 CCR Section 1300.75.4(b), Federally Qualified Health Centers (FQHC) and other clinics.

7. CONTRACTOR'S OBLIGATIONS

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

2. If Contractor's incurred claims reported in accordance with Exhibit A3, Subsection 5, Paragraph 5.a.i.3 above includes withholds from payments made to Network Providers, Contractor must provide to DHCS a report, in a form and manner specified by DHCS, detailing the basis for those withhold.

EXHIBIT A4: MANAGEMENT INFORMATION SYSTEM (MIS)

1. MANAGEMENT INFORMATION SYSTEM CAPABILITY

1. Contractor's Management and Information System (MIS) shall be fully compliant with 42 CFR section 438.242 requirements and shall have the capability to capture, edit, and utilize various data elements for both internal management use as well as to meet the data quality and timeliness requirements of DHCS's Encounter Data submission. All data related to this Contract shall be available to DHCS and to the Centers for Medicare and Medicaid Services (CMS) upon request. 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;

        2. Monthly all users;

        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;

        6. Total paid to each provider, including capitation payment, FFS payment, incentive payment and any other payment;

        7. Calculation of required performance measures.

        8. The provider who delivers services.

    e. Grievance and appeals information.

    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 SECTION 4. WRITTEN MEMBER INFORMATION.
5. If they are accepting new patients.

g. Program Data

h. Template Data

i. Electronic dental records

j. Financial information as specified in SECTION 9. ADMINISTRATIVE DUTIES/ RESPONSIBILITIES; and

k. Member and Member's authorized representative Alternative Format Selection(s) AFS.

l. Prior Authorization requests and a specialty referral system as specified in EXHIBIT A7: UTILIZATION MANAGEMENT.

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 at the commencement of the Operations Period and for the duration of this Contract.

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' 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.

5. Contractor shall implement and maintain a publicly accessible, standards-based Patient Access Application Programming Interface (API), and a provider directory API, as described in 42 CFR sections 431.60 and 431.70, and in APL 22-013. Contractor must operate the API in the manner specified in 45 CFR section 170.215 and include information per 42 CFR section 438.242(b)(5) and (6).

   Contractor's MIS must have the capability to transmit and consume data files with and from DHCS, Subcontractors, Network Providers, other State and federal and local governmental agencies, and other sources as needed to support Care Coordination and overall administration of the Medi-Cal program. That data must be able to be transmitted.

2. ENCOUNTER DATA SUBMITTAL

1. Contractor must maintain a MIS that collects and reports Encounter Data to DHCS in compliance with 42 CFR 438.242, and pursuant to applicable DHCS All Plan Letters (APL).

2. Contractor shall implement policies and procedures for ensuring the complete, accurate, and timely submission of Encounter Data to DHCS for all items and services furnished to a Member under this Contract, whether directly or through Network Provider Agreement or Subcontractor Agreements. Encounter data shall be submitted on at least a monthly basis in a form and manner specified by DHCS.

3. Contractor shall require Subcontractors, Network Providers and Out-of-Network Providers to submit claims and Encounter Data to Contractor to meet its administrative functions and the requirements set forth in this Section. Contractor shall have in place mechanisms, including edit and reporting systems sufficient to assure encounter data is complete, accurate and timely prior to submission to DHCS. Contractor shall ensure the completeness, accuracy and timeliness of all Network Provider, Subcontractor and Out-of-Network Provider Encounter Data regardless of whether Subcontractor, Network Provider or Out-of-Network Provider is reimbursed on a Fee-For-Service (FFS) or capitated basis.

4. Contractor shall submit complete, accurate, reasonable, and timely Encounter Data within six (6) business days of the end of each month following the month of payment under this Contract or as otherwise agreed upon by DHCS, and in the format specified by DHCS.

5. DHCS shall review and validate the Encounter Data for completeness, accuracy, and timeliness.

6. If DHCS finds deficiencies regarding the completeness, accuracy, and timeliness of the Encounter Data, DHCS will notify the Contractor in writing of the deficiency and request correction and resubmission of the relevant Encounter Data. 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. 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.

7. Contractor shall ensure all Encounter Data is submitted to DHCS within two (2) months of receipt of an Encounter. Subcontractors, Network Providers and Out-of-Network Providers must comply with this Provision for submission of Encounter Data to Contractor. All Encounter Data shall be submitted to Contractor no later than twelve (12) months from the date of service.

8. Contractor shall perform an annual audit of a Statistically Valid Sample (SVS) of the Encounter Data submitted by, or on behalf of, Contractor on an annual basis and report to the Department the findings. For any findings less than 99.0% data accuracy, contractor shall develop a report to the Department which will discuss the systemic cause of the misinformation, remediation steps taken to remedy the program, and projected implementation date of the findings. Contractor shall continue to report on the progress every three (3) months until the remediation is complete.

9. DHCS or its agent will periodically, but not less frequently than once every three (3) years, conduct an independent audit of the Encounter Data submitted by, or on behalf of, Contractor, in accordance with 42 CFR 438.602(e).

3. NETWORK DATA REPORTING

1. Contractor must maintain a MIS that collects and transmits Network Provider Data to DHCS in compliance with 42 CFR sections 438.207, 438.604(a)(5), and 438.606, and in accordance with APL 17-005 and all applicable DHCS APLs.

2. Contractor must implement policies and procedures for ensuring the complete, accurate, reasonable, and timely submission of Network Provider Data, Subcontractor data, to DHCS, as defined in State and federal law, all applicable DHCS APLs, DHCS companion guide, and this Contract, that accurately represents Contractor's Provider Network, whether directly or through Subcontractor Agreements, or Network Provider Agreements. Network data shall be submitted on at least a monthly basis in the form and manner specified by DHCS.

3. For all data submissions required by 42 CFR 438.604, Contractor shall submit its certification of

compliance concurrently with the submission of its data, documentation, or information pursuant to 42 CFR 438.606(c). Contractor's certification(s) shall be certified by Contractor's Chief Executive Officer; Chief Financial Officer; or an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer. Contractor's Chief Executive Officer or Chief Financial Officer is solely responsible for the certification.

4. Contractor must require all Network Providers, Subcontractors, to submit Network Provider Data to Contractor to meet Contractor's administrative functions and the requirements set forth in this Contract. Contractor must have mechanisms, including edit and reporting systems, sufficient to ensure Network Provider Data is complete, accurate, reasonable, and timely, as defined in State and federal law and all applicable DHCS APLs, prior to submission to DHCS. Contractor must ensure the completeness, accuracy, reasonableness, and timeliness of all Network Provider, Subcontractor, and Network Provider Data regardless of contracting arrangements.

5. Contractor must submit complete, accurate, reasonable, and timely Network Provider Data within 10 calendar days following the end of each month, or as mandated through federal law, and in a form and manner specified by DHCS. Contractor must certify all Network Provider Data as set forth in 42 CFR section 438.604.

6. Pursuant to 42 CFR 438.3(s), to any extent applicable, Contractor shall ensure that Encounter Data for outpatient drugs from participants in the federal 340B program contains DHCS-required identifiers to maintain compliance with the requirements of 42 USC 256b(a)(5)(A)(i). Contractor shall also comply with the provisions of W & I Code 14105.46.

7. Pursuant to 42 CFR 438.606. Subcontractors and Network Providers must comply with this Section for submission of Network Provider Data to Contractor.

8. DHCS will review and validate Contractor's Network Provider Data for completeness, accuracy, reasonableness, and timeliness.

4. 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.

5. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Contractor shall comply with SECTION 5. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) requirements and all Federal and State regulations promulgated from this Act, as they become effective.

6. 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 ninety days prior to assumption of operations. 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.

7. PARTICIPATION IN THE STATE DRUG REBATE PROGRAM

1. To any extent applicable, Contractor shall participate in the federal and State drug rebate program by including all utilization data for both current and retroactive outpatient drugs in its Encounter Data as necessary to meet federal requirements set forth in 42 USC section 1396r-8(k)(2).

    a. Encounter Data for outpatient drugs shall comply with Section 1927(b)(1)(A) of the Social Security Act.

    b. All outpatient drug Encounter Data shall include, at a minimum, the total number of units of each dosage form, strength, and package size, by National Drug Code, for each eligible Physician administered drug claim.

2. To any extent applicable, Contractor shall assist DHCS in resolving manufacturer rebate disputes due to Provider Network or Encounter Data submissions.

8. NETWORK DATA SUBMISSIONS

1. Contractor shall require all Network Providers and Subcontractors to submit Network data to Contractor to meet its administrative functions and the requirements set forth in this Provision. Contractor shall have in place mechanisms, including edit and reporting systems sufficient to assure Network data is complete, accurate, and timely prior to submission to DHCS. Contractor shall ensure the completeness, accuracy, and timeliness of all Subcontractor and Network Provider data regardless of contracting arrangements.

2. Contractor shall submit complete, accurate, and timely Network data within ten (10) calendar days following the end of each month under this Contract or as otherwise agreed upon by DHCS, and in

the format specified by DHCS. Contractor shall certify all Network data as set forth in 42 CFR 438.606.

3. DHCS shall review and validate Network data for completeness, accuracy, and timeliness. If DHCS finds deficiencies regarding the completeness, accuracy, and timeliness of the Network data, DHCS may notify Contractor in writing of the deficiency and request correction and resubmission of the relevant data. Contractor shall ensure that corrected Network data is resubmitted within fifteen (15) calendar days of the date of the DHCS notice. Upon Contractor's written request, DHCS may grant an extension for submission of corrected Network data.

9. PROGRAM DATA REPORTING

1. Contractor must maintain a MIS that consumes and transmits Program Data to DHCS in accordance with all applicable DHCS APLs.

2. Contractor must implement policies and procedures for ensuring the complete, accurate, and timely submission of Program Data to DHCS, as defined in State and federal law, all applicable DHCS APLs, and this Contract, including, but not limited to, all Grievances, Appeals, out-of-Network requests, medical exemption request denial reports and other continuity of care requests, and Primary Care Provider assignments received or determined by Contractor, whether directly or through Subcontractor Agreements or Network Provider Agreements.

3. Contractor must require all Network Providers, Subcontractors, and Out-of-Network Providers to submit Program Data to Contractor to meet Contractor’s administrative functions and the requirements set forth in this Contract. Contractor must have mechanisms, including edit and reporting systems, sufficient to ensure Program Data is complete, accurate, and timely, as defined in State and federal law and all applicable DHCS APLs, prior to submission to DHCS. Contractor must ensure the completeness, accuracy, and timeliness of all Network Provider, Subcontractor, and Out-of-Network Provider Program Data regardless of contracting arrangements.

4. Contractor must submit complete, accurate, and timely Program Data within ten (10) calendar days following the end of each month, or as mandated through federal law, and in a form and manner specified by DHCS. Contractor must certify all Program Data as set forth in 42 CFR section 438.606. Contractor shall ensure that Network Providers, Subcontractors, and Out-of-Network Providers comply with this Provision for submission of Program Data to Contractor.

5. DHCS will review and validate Contractor’s Program Data for completeness, accuracy, and timeliness.

6. If DHCS finds deficiencies regarding the completeness, accuracy, or timeliness of Contractor’s

Program Data and notifies Contractor in writing of the deficiencies and requests correction and resubmission of the relevant Program Data, Contractor must ensure that corrected Program Data is resubmitted within fifteen (15) calendar days of the date of DHCS' notice, or as mandated through federal law. Upon Contractor's written request, DHCS may, in its sole discretion, grant an extension for submission of corrected Program Data.

10. TRACKING AND SUBMITTING ALTERNATIVE FORMAT SELECTIONS (AFS)

1. Contractor shall have and maintain systems that are able to, at a minimum, perform the following functions:

    a. Collect and store Member AFS, as well as the AFS of a Member's authorized representative.

    b. Share Member AFS data with DHCS as specified in the Alternative Format Data Process Guide included in dental APL 22-011.

    c. Track Member's authorized representative AFS data and submit to DHCS when requested.

2. Contractor shall submit all Member AFS data that has been collected in a one-time file upload to the DHCS Alternate Formats database, in the time and manner specified in dental APL 22-011.

3. After Contractor's one-time file upload is completed, Contractor shall submit to DHCS all new Member AFS at the time of the Member's request. Submissions shall be submitted online through the AFS application system, or by calling the AFS Helpline at (833) 284-0040.

4. DHCS will share Member AFS data with Contractor on an ongoing basis. DHCS will send Contractor a weekly AFS file from the DHCS Alternate Formats database. The DHCS weekly file data elements and file path is included in the dental APL 22-011 AFS Technical Guidance attachment. Contractor must utilize the weekly DHCS AFS file data to update their records and provide Member materials in the requested alternative formats.

5. Contractor shall submit to DHCS policies and procedures for collecting and sharing AFS data in accordance with the requirements in dental APL 22-011.

11. INTEROPERABILITY API SYSTEM REQUIREMENTS

1. In order to ensure Contractor applies the same standards for Encounter Data contained in SECTION 2. ENCOUNTER DATA SUBMITTAL to data collected and made available through its

API, Contractor must verify that data collected from Network Providers and Subcontractors to be made available through the API is accurate, complete, and timely, and collected in accordance with the oversight and monitoring guidance in APL 22-026. Contractor must make all collected data available to DHCS and CMS, upon request.

2. Contractor must conduct routine testing and monitoring of its API functions, and applying system updates as appropriate, to ensure that the API is compliant and functional.

3. Contractor may deny or discontinue any third-party application connection to its API if Contractor determines, that continued access presents an unacceptable level of risk to the security of protected health information on its systems. Contractor's dental determination shall be made in accordance with the guidance provided in APL 22-013.

EXHIBIT A5: QUALITY IMPROVEMENT AND ORAL HEALTH ACCESS TRANSFORMATION PROGRAM

1. GENERAL REQUIREMENTS

1. Contractor shall implement an effective Quality Improvement and Oral Health Access Transformation Program (QIOHATP) that includes, at a minimum, the standards set forth in Title 28 California Code of Regulations (CCR) Section 1300.70 and 42 CFR 438.330 and 438.340, and be consistent with the principles outlined in the DHCS Comprehensive Quality Strategy. 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, and take appropriate action to improve upon Oral Health Access. Contractor shall be accountable for the quality and Oral Health Access 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 Contractor on behalf of a Medi-Cal beneficiary for malpractice committed by a Subcontractor.

2. In accordance with 42 Code of Federal Regulations (CFR) § 438.330, Contractor shall establish and implement an ongoing comprehensive quality assessment and performance improvement program, which must include at the minimum the following elements:

    a. Quality Improvement Projects in accordance with SECTION 7. QIOHATP POLICIES AND PROCEDURES including any required by DHCS and Centers for Medicare and Medicaid Services (CMS) that focus on both clinical and non-clinical areas.

    b. Collection and submission of performance measurement data required by DHCS and CMS in accordance with EXHIBIT A6: 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 A13: CASE MANAGEMENT AND COORDINATION OF CARE.

3. Contractor must apply the principles of continuous quality improvement (CQI) to all aspects of Contractor's service delivery system through analysis, evaluation, and systematic enhancements of the following:

    a. Quantitative and qualitative data collection and data-driven decision-making;

b. Up-to-date evidence-based practice guidelines and explicit criteria developed by recognized sources or appropriately certified professionals or, where evidence-based practice guidelines do not exist, consensus of professionals in the field;

c. Feedback provided by Members and Network Providers in the design, planning, and implementation of its CQI activities;

d. Other issues identified by Contractor or DHCS.

4. Contractor must develop Population Health Management interventions designed to address Social Drivers of Health (SDOH), reduce disparities in oral health outcomes experienced by different subpopulations of Members, and work towards achieving Oral Health Access by:

   a. Developing access focused interventions intended to address disparities in the utilization and outcomes of oral healthcare; and

   b. Engaging in a Member and family-centric approach in the development of interventions and strategies, and in the delivery of oral health care services.

   c. Contractor must ensure that the QIOHATP requirements of this Contract are applied to the delivery of oral health services.

2. QIOHATP OVERVIEW

Contractor must maintain a QIOHATP which includes the following, at a minimum:

1. Oversight and participation by Contractor's Governing Body;

2. Creation and designation of a Quality Improvement and Oral Health Access Committee (QIOHAC) whose activities are supervised by Contractor's Dental Director or the Dental Director's designee, in collaboration with the Contractor's Chief Oral Health Access Officer;

3. Supervision of QIOHATP activities by Contractor's dental director and the Chief Oral Health Access Officer; and

4. The participation of a broad range of Participants, including Network Providers that must consist of both dentists and allied dental professionals such as dental hygienists, and county partners in the process of QIOHATP development and performance review.

3. GOVERNING BODY

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

1. Approve the overall QIOHATP and the annual report of the QIOHATP.

2. Appoint an accountable entity or entities within Contractor's organization to provide oversight of the QIOHATP.

3. Routinely receive written progress reports from the Quality Improvement and Oral Health Access Committee (QIOHAC) describing actions taken, progress in meeting QIOHATP objectives, and improvements made.

4. Direct the operational QIOHATP to be modified on an ongoing basis and tracks all review findings for follow-up to ensure compliance with the QI and Oral Health Access standards in this Contract and the DHCS Comprehensive Quality Strategy.

4. QUALITY IMPROVEMENT AND ORAL HEALTH ACCESS COMMITTEE (QIOHAC)

1. Contractor must implement and maintain a QIOHAC designated and overseen by its Governing Body. Contractor's Dental Director or the Dental Director's designee must head QIOHAC in collaboration with Contractor's Chief Oral Health Access officer. Contractor must ensure that a range of Network Providers, including but not limited to dentists and allied dental professionals such as dental hygienists, Subcontractors, and Members, actively participate in the QIOHAC or in any sub-committee that reports to the QIOHAC. The Subcontractors and Network Providers that are part of QIOHAC must be representative of the composition of the Contractor's Provider Network and include, at a minimum, Network Providers who provide health care services to Members affected by Oral Health Disparities, Limited English Proficiency (LEP) Members, Children with Special Health Care Needs (CSHCN), Seniors and Persons with Disabilities (SPDs) and persons with chronic conditions.

   The QIOHAC's responsibilities include the following:

   a. Analyze and evaluate the results of QI and Oral Health Access activities including annual review of the results of performance measures, utilization data, consumer satisfaction surveys, and the findings and activities of other oral health Contractor committees such as the CAC (SECTION 8. COMMUNITY ADVISORY COMMITTEE).

   b. Institute actions to address performance deficiencies, including policy recommendations;

and

c. Ensure appropriate follow-up of identified performance deficiencies.

2. Contractor must ensure Member confidentiality is maintained in Quality Improvement (QI) discussions and ensure avoidance of conflict of interest among the QIOHAC members.

3. Contractor must ensure that the QIOHAC meets at least quarterly, and more frequently if needed. A written summary of QIOHAC activities, as well as QIOHAC activities of its Fully Delegated Subcontractors, findings, recommendations, and actions must be prepared after each meeting and submitted to Contractor's Governing Board. Contractor must also submit the written summary to DHCS upon request.

4. Contractor must make the written summary of the QIOHAC activities publicly available on the Contractor's website at least on a quarterly basis.

5. Contractor must ensure that its Fully Delegated Subcontractors maintain a QIOHAC that meets the requirements set forth in this Section. Contractor must also ensure that they report to Contractor's QIOHAC quarterly, at a minimum.

5. PROVIDER PARTICIPATION

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

Contractor must ensure that its Network Providers and Fully Delegated Subcontractors, participate in the QIOHATP and Population Needs Assessment (PNA) as described in SECTION 7.3. POPULATION NEEDS ASSESSMENT (PNA), Contractor must incorporate its Fully Delegated Subcontractor data and results into the development of its PNA, as described in SECTION 7.3. POPULATION NEEDS ASSESSMENT (PNA). Contractor must regularly update its Network Providers, Fully Delegated Subcontractors, on activities, findings, and recommendations of the QIOHAC's QIOHATP and PNA results.

6. SUBCONTRACTOR 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 must, at a minimum, specify the following requirements in its Subcontractor agreements, as applicable:

a. Quality improvement or Oral Health Access responsibilities, and specific subcontracted functions and activities of Subcontractor.

b. The schedule of Contractor's ongoing oversight, monitoring, and evaluation of Subcontractor including quarterly reporting and annual review of Subcontractors performance.

c. Subcontractor's reporting requirements and Contractor's approval procedure of Subcontractor's reports.

d. Subcontractor's obligation to report findings and actions of QI or Oral Health Access activities at least quarterly to Contractor; and,

e. Contractor's actions/remedies if Subcontractor's obligations are not satisfactorily performed.

2. Contractor must maintain an adequate oversight procedure to ensure Subcontractor's compliance with all QI or Oral Health Access delegated activities that, at a minimum:

a. Evaluates Subcontractor's ability to perform the delegated activities, including an initial determination that Subcontractor have the administrative capacity, experience, and budgetary resources to fulfill their contractual obligations;

b. Ensures Subcontractor meet QI and Oral Health Access standards set forth in this Contract; and,

c. Includes Contractor's continuous monitoring, evaluation, and approval of its delegated functions to Subcontractor. Contractor must make the findings of its continuous monitoring and evaluation of the Subcontractor and available to DHCS at least annually, but more frequently when directed by DHCS.

7. QIOHATP POLICIES AND PROCEDURES

Contractor must develop, implement, maintain, and update upon DHCS request, its QIOHATP policies and procedures, reporting the following:

1. Contractor's commitment to the delivery of quality and accessible oral health care services;

2. Contractor's and Fully Delegated Subcontractor's organizational chart, listing the key staff and the

committees responsible for QI and Oral Health Access activities, including reporting relationships of QIOHATP committee(s) to executive staff;

3. Qualifications (education, experience, and training) and identification of staff who are responsible for QI and Oral Health Access activities;

4. A process for sharing QIOHATP findings as well as obtaining and documenting feedback with its Subcontractors and Network Providers;

5. The role, structure, and function of the QIOHAC;

6. The policies and procedures to ensure that all Covered Services are available and accessible to all Members regardless of racial, ethnic, language, geographic, disability, neurodiversity, sexual orientation, gender identity, age groups, and any applicable groups defined in Penal Code section 422.56, and that all Covered Services are provided in a culturally and linguistically appropriate manner;

7. The policies and procedures designed to identify, evaluate, and reduce Oral Health Disparities, by performing the following:

    a. Analyzing data to identify differences in quality of care and utilization, as well as the underlying reasons for variations in the provision of care to its Members;

    b. Developing access-focused interventions to address the underlying factors of identified Oral Health Disparities, including Social Drivers of Health (SDOH); and

    c. Meeting disparity reduction targets for specific populations and/or measures as identified by DHCS and as directed under SECTION 10. EXTERNAL QUALITY REVIEW REQUIREMENTS.

8. Description of the integration of Utilization Management (UM) activities into the QIOHATP as specified in EXHIBIT A7: UTILIZATION MANAGEMENT, including a process to integrate reports on the number and types of service requests, denials, deferrals, modifications, Appeals, and Grievances to the Dental Director or the Dental director’s designee;

9. Policies and procedures to adopt, disseminate, and monitor the use of clinical practice guidelines that:

    a. Are based on valid and reliable clinical evidence or a consensus of oral health care

professionals in the relevant field;

b. Consider the needs of Members;

c. Stem from recognized organizations that develop or promulgate evidence-based clinical practice guidelines, or are developed with involvement of providers from appropriate dental specialty areas (e.g., endodontics, prosthodontics, etc.);

d. Have been reviewed by Contractor's Dental Director, as well as Subcontractors and Network Providers, as appropriate; and

e. Are reviewed and updated at least every two years;

10. The inclusion of Population Health Management (PHM) activities, including the findings of the annual Population SECTION 7.3. POPULATION NEEDS ASSESSMENT (PNA);

11. Mechanisms to detect both over- and under-utilization of services;

12. Mechanisms to continuously monitor, review, evaluate, and improve access to and availability of all Covered Services. The mechanisms must include oversight processes that ensure Members are able to obtain Medically Necessary appointments within established standards for time or distance, timely access, and alternative access in accordance with as defined in APLs 17-008 and 18-003 and W&I Code sections 14197 and 14197.04;

13. Mechanisms to continuously monitor, review, evaluate, and improve quality and Oral Health Access of clinical care services provided, including, but not limited to, preventive services for children and adults, primary care, specialty, emergency, and ancillary care services. The mechanisms must also include oversight processes that ensure Members are able to obtain minimally invasive services and that the provision of anesthesia services is timely and geographically accessible, when necessary, as defined in APLs 17-008 and 18-003 and W&I Code sections 14197 and 14197.04.

14. Mechanisms to continuously monitor, review, evaluate, and improve availability, coordination, case management, and continuity of care services to all Members, including SPDs, CSHCN, Members with chronic conditions, Members experiencing homelessness, Members recently released from incarceration, and children and youth in child welfare. The mechanisms must include oversight processes that ensure Members are able to obtain coordination and tracking of dental and medical referrals from initiation of the referral to the completion.

8. 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 more than one county, Contractor must include both counties in a QIP unless otherwise approved by DHCS.

    d. Contractor shall comply with any All Plan Letters (APLs) existing at Contract effective date as well as any subsequent updates, and shall use the QIP reporting format designated therein, including timelines, templates and content requirements 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 oral 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 A6: PERFORMANCE MEASURES AND BENCHMARKS.

7. Planning and initiation of strategies for sustaining or increasing improvement beyond the duration of the QIP.

9. QUALITY IMPROVEMENT AND ORAL HEALTH ACCESS ANNUAL PLAN

Contractor must develop and submit an annual QI and Oral Health Access plan to DHCS, as directed below.

1. Develop a QI and Oral Health Access plan annually for submission to DHCS that includes the following, at a minimum:

    a. A comprehensive assessment of the QI and Oral Health Access activities undertaken, including an evaluation of the effectiveness of QI interventions;

    b. A written analysis of required quality performance measure results, and a plan of action to address performance deficiencies, including analyses of each Fully Delegated Subcontractor's performance measure results and actions to address any deficiencies;

    c. An analysis of actions taken to address any Contractor-specific recommendations in the annual External Quality Review (EQR) technical report and Contractor's specific evaluation reports;

    d. An analysis of the delivery of services and quality of care of Contractor and its Fully Delegated Subcontractors, based on data from multiple sources, including quality performance results, Encounter Data, Grievances and Appeals, Utilization Review, and the results of consumer satisfaction surveys;

    e. Planned access-focused interventions to address identified patterns of over- or under- utilization of oral health care services;

    f. A description of Contractor's commitment to Member and/or family focused care through Member and community engagement such as review of CAC findings, Member listening sessions, focus groups or surveys, and collaboration with local community organizations; and how Contractor utilizes the information from this engagement to inform Contractor policies and decision-making;

g. PHM activities and findings as outlined in SECTION 7. CULTURAL AND LINGUISTIC PROGRAM; and

h. Outcomes/findings from Performance Improvement Projects (PIPs), consumer satisfaction surveys and collaborative initiatives.

To the extent that Contractor delegates its QI and Oral Health Access activities to its Fully Delegated Subcontractors, Contractor's QI and Oral Health Access annual plan must include evaluation and findings specific to the Fully Delegated Subcontractor's performance.

2. Provide annual copies of all final reports of independent private accrediting agencies (e.g., NCQA) relevant to Contractor's, Fully Delegated Subcontractor's, and Medi-Cal line of business, including:

a. Accreditation status, survey type, and level, as applicable;

b. Accreditation agency results, including recommended actions or improvements, corrective action plans, and summaries of findings; and

c. Expiration date of the accreditation.

In addition, pursuant to 42 CFR section 438.332, Contractor must authorize independent private accrediting agencies to provide DHCS a copy of Contractor's most recent accreditation review annually.

3. Provide an annual report to DHCS that includes an assessment of all Subcontractors' performance of its delegated QI or Oral Health Access activities.

4. Contractor must make the QI and Oral Health Access plan publicly available on its website on an annual basis.

10. EXTERNAL QUALITY REVIEW REQUIREMENTS

At least annually or more frequently as directed by DHCS, Contractor must cooperate with and assist the External Quality Review Organization (EQRO) designated by DHCS in conducting its EQR reviews of Contractor in accordance with 42 USC section 1396u-2(c)(2), 42 CFR sections 438.310 *et seq.*, and 22 CCR section 53860(d).

Contractor must comply with all requirements set forth in 42 CFR sections 438.310 et seq. as well as

activities specified in APL 18-002, and the CMS EQR protocol which provides detailed instructions on how to complete the EQR activities.

In addition, Contractor must also comply with the following requirements:

10.1. QUALITY PERFORMANCE MEASURES

On an annual basis, Contractor must track and report on a set of Quality Performance Measures and Oral Health Access measures identified by DHCS in accordance with all of the following requirements:

a. Contractor must work with the EQRO to conduct an onsite assessment of the Quality Measure Compliance Audit and DHCS-required performance measures;

b. Contractor must calculate and report all required quality performance and Oral Health Access measures at the reporting unit level as directed by DHCS. Contractor must separately report to DHCS all required performance measure results at the reporting unit level for its Fully Delegated Subcontractors;

    1. Contractor must calculate performance measure rates, to be verified by the EQRO;

    2. Contractor must report audited results on the required performance measures to DHCS no later than June 15 of each year or on another date as established by DHCS. Contractor must initiate reporting on required Quality Performance Measures for the reporting cycle following the first year of this Contract operation;

    3. Contractor must exceed the DHCS-established Minimum Performance Level (MPL) for each required Quality Performance Measure and Oral Health Access measure selected by DHCS. Also exceed the DHCS-established MPL for each required Quality Performance Measure and Oral Health Access measure selected by DHCS.

    4. Contractor must meet Oral Health Disparity reduction targets for specific populations and measures as identified by DHCS.

    5. In accordance with 42 CFR section 438.706, W&I Code section 14197.7, and EXHIBIT E: ADDITIONAL PROVISIONS and EXHIBIT A5: QUALITY IMPROVEMENT AND ORAL HEALTH ACCESS TRANSFORMATION PROGRAM, DHCS may impose financial sanctions or corrective actions on Contractor for failure to meet required MPLs. DHCS may require Contractor to make changes to its executive personnel if a Contractor has persistent and pervasive poor performance as evidenced by multiple performance

measures consistently below the MPL over multiple years. DHCS may also limit Contractor's service area expansion or suspend Member Enrollment based on Contractor's persistent and pervasive poor performance on Quality Performance Measures.

In addition to sanctions and corrective actions, DHCS reserves the right, subject to actuarial judgment and generally accepted actuarial principles and practices, to consider Contractor's performance on specified quality and access benchmarks, as determined by DHCS and communicated to Contractor in advance of each applicable Rating Period, within the determination of Capitation Payment rates for that Rating Period.

Contractor is responsible for ensuring that its Fully Delegated Subcontractors MPL, as applicable. If its Fully Delegated Subcontractor fails to exceed the DHCS-established MPL, Contractor must have policies and procedures in place to subject its Fully Delegated Subcontractors to appropriate corrective actions, which may include, but are not limited to, financial sanctions, corrective action plans, and a requirement to change its executive personnel.

10.2. PERFORMANCE IMPROVEMENTS PROJECTS (PIPs)

a. Contractor must conduct or participate in PIPs, including any PIP required by CMS, in accordance with 42 CFR section 438.330. Contractor must conduct or participate in, at a minimum, two (2) PIPs per year, as directed by DHCS. At its sole discretion, DHCS may require Contractor to conduct or participate in additional PIPs, including statewide PIPs. DHCS may also require Contractor to participate in statewide collaborative PIP workgroups.

b. Contractor must have policies and procedures in place to ensure that its Fully Delegated Subcontractors also conduct and participate in PIPs and any collaborative PIP workgroups as directed by CMS or DHCS.

c. Contractor must comply with the PIP requirements outlined in APL 18-002 and must use the PIP reporting format as designated therein to request DHCS' approval of proposed PIPs.

d. Each PIP must include the following:

    1. Measurement of performance using objective quality indicators;

    2. Implementation of access-focused interventions to achieve improvement in the access to and quality of care;

3. Evaluation of the effectiveness of the interventions based on the performance measures; and

4. Planning and initiation of activities for increasing or sustaining improvement.

e. Contractor must report the status of each PIP at least annually to DHCS.

10.3. CONSUMER SATISFACTION SURVEY

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

As part of the independent assessments detailed in the CalAIM Special Terms and Conditions (STCs), item 10.c and 10.c.ii, detailed below, the State must make recommendations for improving the consumer experience in dental managed care delivery systems.

a. On an annual basis until January 1, 2026, Contractor must timely provide all data requested by the EQRO in a format designated by the EQRO in conducting a consumer satisfaction survey. Beginning January 1, 2026, Contractor must publicly post the annual results of its, and its Fully Delegated Subcontractor's Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey on Contractor's website, including results of any supplemental questions as directed by DHCS.

b. If Contractor has HPA prior to January 1, 2026, and reports its CAHPS data to the NCQA, Contractor must publicly post the annual results of its CAHPS survey, and its Fully Delegated Subcontractors with NCQA HPA, on Contractor's website, including results of any supplemental questions as directed by DHCS.

c. Contractor must incorporate results from the consumer satisfaction survey in the design of quality improvement and Oral Health Access activities.

10.4. CONSUMER EXPERIENCE AND ADVOCATE ENGAGEMENT

As part of all Independent Assessments detailed in the STCs, Contractor must make recommendations for improving customer experience in dental managed care delivery systems. As part of the recommendations for improving the customer experience, Contractor must:

1. Ensure that the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey or similar consumer satisfaction survey is conducted annually for Members enrolled in the Medi-Cal Dental Managed Care plans.

2. Contract must publicly post the annual results of its, and its Fully Delegated Subcontractor's, Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey on Contractor's website, including results of any supplemental questions as directed by DHCS.

3. Contractor must incorporate results from the consumer satisfaction survey in the design of quality improvement and Oral Health Access activities.

4. On an annual basis until January 1, 2026, or as otherwise directed by DHCS, whichever later, Contractor must timely provide all data requested by the EQRO in a format designated by the EQRO in conducting a consumer satisfaction survey.

10.5. NETWORK ADEQUACY VALIDATION

Contractor must participate in the validation of Network adequacy from the preceding twelve (12) months to comply with requirements set forth in 42 CFR sections 438.68, and as applicable 438.14(b)(1) and 438.358.

10.6. ENCOUNTER DATA VALIDATION

At intervals determined by DHCS, its contracted EQRO will conduct validation of Encounter Data assessing the completeness, accuracy, and timeliness of Encounter Data submitted by Contractor to DHCS.

10.7. FOCUSED STUDIES

DHCS may choose to conduct an external review of focused clinical and/or non-clinical topic(s) as part of its review of quality outcomes and timeliness of, and access to, services provided by Contractor.

10.8. TECHNICAL ASSISTANCE

In accordance with 42 CFR section 438.358(d) and at the direction of DHCS, the EQRO may provide technical guidance to Contractor as described in 42 CFR 438.310(c)(2) in order to assist Contractor in conducting mandatory and optional activities described in 42 CFR section 438.358 and this Contract regarding information for the EQR and the resulting EQR technical report.

11. QUALITY CARE FOR CHILDREN

Contractor must maintain a robust program to ensure the provision of all oral health services to Members

less than 21 years of age. Contractor must also maintain mechanisms to identify and improve on gaps in the quality of and access to care in each of the following areas:

1. Scope of Services

    a. Contractor must ensure the provision of all oral health screening, preventive and Medically Necessary diagnostic, and treatment services for Members less than 21 years of age in accordance with EXHIBIT A12: SCOPE OF SERVICES;

    b. Contractor must actively promote EPSDT screenings and AAP (American Academy of Pediatrics) Bright Futures preventive services to Members and their families;

    c. Contractor must identify Members who have not utilized preventive services and ensure outreach to these Members in a culturally and linguistically appropriate manner;

    d. Contractor must conduct ongoing training, at least once every two years, for Network Providers on required preventive oral health services, including EPSDT services for Members less than 21 years of age as outlined in SECTION 5. NETWORK PROVIDER TRAINING, to ensure providers are able to support Members and families in fully utilizing EPSDT services.

2. Utilization Management

    Contractor must ensure that all requirements outlined in EXHIBIT A7: UTILIZATION MANAGEMENT apply to the review and provision of Medically Necessary services for Members less than 21 years of age
    .
3. Population Health Management and Coordination of Care

    a. Contractor must ensure that all requirements outlined in SECTION 7. CULTURAL AND LINGUISTIC PROGRAM, including the development of the annual PNA, apply to Members less than 21 years of age;

    b. Contractor’s Population Health Management Strategy (PHMS), as described in SECTION 7. CULTURAL AND LINGUISTIC PROGRAM, must contain a specific section focused on how the Contractor will provide PHM services to Members less than 21 years of age, including but not limited to, Basic PHM, EPSDT services, Care Coordination services, and Early Intervention Services;

4. Network and Access to Care

    a. Contractor must ensure that each Member less than 21 years of age has an assigned Primary care Dentist as well as access to Specialists for Covered Services and Medically Necessary services, in accordance with EXHIBIT A11: ACCESS AND AVAILABILITY;

    b. Contractor must maintain and continually monitor, improve, and evaluate cultural and linguistic services that support the delivery of Covered Services to Members less than 21 years of age, in accordance with SECTION 7. CULTURAL AND LINGUISTIC PROGRAM

5. Quality and Oral Health Access

    a. Contractor must identify and address underutilization of children's preventive services including but not limited to EPSDT services;

    b. Contractor must report on DHCS-identified quality and Oral Health Access performance measures related to health care services for Members less than 21 years of age, and must exceed any DHCS-specified MPL, in accordance with SECTION 10.1. QUALITY PERFORMANCE MEASURES;

    c. Contractor must engage with local entities when developing interventions and strategies to address deficiencies in performance measures related to health care services for Members less than 21 years of age;

    d. Contractor must meet any Oral Health Disparity reduction targets for specific populations and measures for Members less than 21 years of age, as identified by DHCS and in accordance with SECTION 10.1. QUALITY PERFORMANCE MEASURES;

    e. Contractor must participate in any value-based payment programs for services provided to Members less than 21 years of age, as directed by DHCS;

    f. Contractor must engage in planned access-focused interventions to address identified gaps in the quality of and access to care for Members less than 21 years of age, including preventive and screening services; and

    Contractor must engage in a Member and family-oriented engagement strategy to QI and Oral Health Access, including children and caregiver representation on the CAC, and using CAC findings and recommendations, and the results of Member listening sessions, focus groups and surveys, to inform QI and Oral Health Access interventions, as outlined in the

CAC (SECTION 8. COMMUNITY ADVISORY COMMITTEE);

12. SITE REVIEW

12.1. GENERAL REQUIREMENT

Contractor shall conduct site reviews on all Primary Care Dentist and specialist service sites in accordance with the provisions outlined in this section and W&I Code Section14182(b)(9).

12.2. 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 percent (5%) 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.

12.3. CREDENTIALING SITE REVIEW

A site review is required as part of the credentialing process when a facility and/or provider is added to Contractor’s Network, unless the provider solely provides dental services as a mobile provider for the Contractor’s Network. If a provider is added to Contractor’s 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.

12.4. CORRECTIVE ACTIONS

Contractor shall ensure that a corrective action plan is developed to correct cited deficiencies and that corrections are completed and verified. Sites that do not correct cited differences are to be terminated from Contractor’s Network.

12.5. DATA SUBMISSION

Contractor shall submit the Facility Site review data to DHCS by January 31 and July 31st of each year. All data elements defined by DHCS shall be included in the data submission report.

12.6. CONTINUING OVERSIGHT

Contractor shall retain accountability for all site review activities whether Provider Monitoring carried out by Contractor, completed by other Medi-Cal Managed Care contractors or Subcontractors.

13. DISEASE SURVEILLANCE

Contractor must implement and maintain procedures for reporting any serious diseases or conditions to both local and State public health authorities and to implement directives from the public health authorities as required by law, including but not limited to, 17 CCR section 2500 *et seq*.

14. CREDENTIALING AND REVALIDATION

Contractor and its Fully Delegated Subcontractors must implement and maintain written policies and procedures regarding the initial credentialing, recredentialing, recertification, and reappointment of Network Providers in accordance with Federal and State law including CMS Medicaid Managed Care Final Rule CMS-2390-F and 42 CFR 438.214(b) and APL 18-004. Contractor and its Fully Delegated Subcontractors must ensure its policies and procedures are reviewed and approved by its Governing Board. Contractor must ensure that the responsibility for recommendations regarding credentialing decisions rests 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.

14.1. STANDARDS

All Network Providers who 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 Network 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.

14.2. DELEGATED CREDENTIALING

Contractor may delegate credentialing and revalidating activities. If Contractor delegates these activities, Contractor shall comply with SECTION 6. SUBCONTRACTOR QUALITY IMPROVEMENT ACTIVITIES.

14.3. CREDENTIALING PROVIDER ORGANIZATION CERTIFICATION

Contractor may obtain credentialing provider organization certification (POC) from the NCQA. Contractor may accept evidence of NCQA POC certification in lieu of a monitoring visit at Network Provider’s facilities.

14.4. DISCIPLINARY ACTIONS

Contractor and its Fully Delegated Subcontractors must implement and maintain a system for reporting serious quality deficiencies that result in suspension or termination of a Network Provider to the appropriate authorities, including DHCS. Contractor and its Fully Delegated Subcontractors must implement and maintain policies and procedures for disciplinary actions including, reducing, suspending, or terminating a provider's privileges. Contractor must implement and maintain a provider appeal process. 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.

14.5. MEDI-CAL AND MEDICARE PROVIDER STATUS

Contractor will verify that their Subcontractors or Network 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) or Restricted Provider Database. As outlined in APL 18-004, Contractor must not maintain contracts with Network Providers or Subcontractors who have been terminated by either Medicare or Medi-Cal, placed on the Suspended and Ineligible Provider List, or placed on a temporary suspension on the Restricted Provider Database.

14.6. PLAN ACCREDITATION

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

Deeming of credentialing certification from other private credentialing organizations will be reviewed on an individual basis.

14.7. CREDENTIALING OF OTHER NON-DENTIST PRACTITIONERS

Contractor and its Fully Delegated Subcontractors 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.

14.8. CHANGES TO CREDENTIALING AND REVALIDATION POLICIES

Future policy changes regarding credentialing and revalidation may be issued through an All Plan Letter. Contractor must make amendments to its policies and procedures in accordance with the policy change(s).

15. DENTAL RECORDS

1. Contractor must ensure the documentation of appropriate Dental Records for Members, pursuant to 28 CCR 1300.80(b)(4) and that Dental Records are available to providers at each Encounter in accordance with 28 CCR section 1300.67.1(c), 42 USC section 1396a(w).

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

    a. For storage and filing of dental records including: collection, processing, maintenance, storage, retrieval identification, and distribution in accordance with Federal and State law.

    b. To ensure that dental records are protected and confidential in accordance with all Federal and State law.

    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).

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

3. Member Dental Record

    Contractor must ensure that a complete, legible Dental Record is maintained for each Member in accordance with 22 CCR section 53861, which reflects all aspects of patient care, including, but not limited to, 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 plan for diagnosis and treatment.

    d. The record shall contain a problem list and a complete record of dental services rendered.

e. A complete dental history including prominent notation in the record of allergies and adverse reactions are prominently noted in the record. The dental history is to be updated at every visit, with a notation to that effect in the record.

f. All informed consent documentation.

g. Reports of Emergency Care provided for dental services (directly by the Network Provider or through an emergency room, if available, or by other means), including any follow-up after Emergency Care the Network Provider provided;

h. Consultations and referrals, (dental and medical as they pertain to dental matters) including for specialists, as well as evidence of review of specialty referrals', pathology, and laboratory reports related to dental services. Any abnormal results shall have an explicit notation in the record, including follow-up;

i. Provision of Member information in alternative formats as required by federal and state law and as stated in SECTION 8. COMMUNITY ADVISORY COMMITTEE and in APL 21-001 and 22-011;

j. Log of Member outreach for all initial, follow up, or missed appointments conducted by the Network Providers office that must include date of contact, method of contact, staff identification of the staff who conducted the outreach, and if a resulting appointment was made; and

k. Oral health instruction.

16. EVALUATION OF CONTRACTOR COMPLIANCE/CORRECTIVE ACTION PLAN (CAP)

16.1. DHCS ISSUED NOTICE OF DEFICIENCIES / CORRECTIVE ACTION PLANS

DHCS will evaluate Contractor’s overall compliance with Contract requirements monthly and can impose any one or a combination of enforcement actions, including imposing sanctions on a DMC plan when the plan fails to comply with contractual obligations or applicable state and federal laws and regulations. When a DMC plan fails to comply with applicable federal and state laws or regulations, or meet contractual obligations, there is good cause to require a CAP from the DMC plan, in order to correct cited deficiencies.

If a notice of violation is Issued from DHCS, Contractor shall ensure that a CAP is developed to correct

cited deficiencies and that corrections are completed and verified within sixty (60) days.

DMC plans are required to provide a monthly status update to DHCS and provide supporting CAP documentation until the CAP is completed. Monthly CAP updates must identify and contain the following:

- The specific deficiency,
- Description of the corrective action,
- Supporting documentation (such as documentation of problems in completing the corrective action, evidence of corrections made, and proof of training),
- Responsible person(s), and
- Implementation dates.

If Contractor fails to correct cited deficiencies as specified in the CAP, then DHCS reserves the right to impose administrative and monetary sanctions for non-compliance pursuant to 42 CFR 438.700 et seq., WIC 14197.7, 42 USC 1396a, and SECTION 18. SANCTIONS.

16.2. CONTRACTOR INITIATED NOTICE OF DEFICIENCY / CORRECTIVE ACTION PLANS

Pursuant to EXHIBIT A19: DELIVERABLE TEMPLATES, If Contractor does not meet the Contract Requirements in any of the reported deliverables, Contractor must include with their deliverable a Corrective Action Plan (CAP) which must identify: The specific deficiency, the causation of the deficiency, description of the corrective steps taken or will be taken to remedy the deficiency supporting documentation (such as evidence of corrections made), Contact person(s); and Implementation dates.

17. SPECIAL QUALITY ASSURANCE STUDIES

Contractor shall perform DHCS directed special quality assurance studies. These studies shall not exceed twenty-four (24) requests per calendar year. Contractor shall develop the study method and submit it for Department approval within seven (7) business days of receipt of the study request from the Department. Contractor shall complete the study as directed and forward the findings to the Department within forty-five (45) calendar days of Department’s approval of the study method.

EXHIBIT A6: PERFORMANCE MEASURES AND BENCHMARKS

1. DETERMINATION OF DENTAL MANAGED CARE PLAN PERFORMANCE

1. The performance measures, quality metrics, benchmarks, and withhold percentages detailed in this Attachment are subject to change as necessary to comply with the requirements of 42 CFR 438.6(b)(3) and to obtain CMS approval. Such updates to the performance measures, quality metrics, benchmarks and withhold percentages shall be made at the sole discretion of DHCS and may be issued in the form of an All Plan Letter or other similar guidance.

    a. DHCS established performance measures and quality metrics for evaluation of dental health plan performance. These performance measures and quality metrics will be used to monitor plan utilization and services to Members. DHCS will establish baselines and benchmarks to monitor annual utilization rates achieved per for each measure. The specified portion of the three percent (3%) withhold of the monthly Capitation Payment will be paid to Contractor if annual benchmarks for each of the following performance measures and quality metrics are met. The performance measures and quality metrics and annual payment percentages are as follows:

Performance Measure and Quality Metric	Withhold Percentage	Methodology
Children: Annual Dental Visits	0.325%	**Numerator**: Number of Members in the denominator who received any dental service (Current Dental Terminology (CDT) D0100-D9999 or Current Procedural Terminology (CPT) 99188, including dental encounters at safety net clinics (SNCs). **Denominator:** Number of Members ages 0-20 with at least 90 days continuous enrollment in the same plan during the measurement period.
Children: Use of Preventive Services	.20%	**Numerator:** Number of Members in the denominator who received any preventive dental service (CDT D1000-D1999 or CPT Code 99188), including dental encounters at SNCs. **Denominator:** Number of Members ages 0-20 with at least 90 days continuous enrollment in the same plan during the measurement period

Performance Measure and Quality Metric	Withhold Percentage	Methodology
Children (Ages 6-9): Use of Sealants	.15%	**Numerator**: Number of Members in the denominator who received a dental sealant (D1351) on a permanent first molar, including dental encounters at SNCs. **Denominator:** Number of Members ages 6-9 with at least 90 days continuous enrollment in the same plan during the measurement period.
Children (Ages 10-14): Use of Sealants	.15%	**Numerator**: Number of Members in the denominator who received a dental sealant (D1351) on a permanent first molar, including dental encounters at SNCs. **Denominator:** Number of Members ages 10-14 with at least 90 days continuous enrollment in the same plan during the measurement period.
Children: Caries Risk Documentation and Education Bundle	.15%	**Numerator:** Number of Members in the denominator who received one of the following dental services: D0601, D0602 and D0603. CRA D0601, D0602, and D0603 (low, medium or high risk) is bundled with nutritional counseling (D1310), and motivational interview (D9993); thus, a query for the CRA codes would capture the bundle of services including SNCs. **Denominator:** Number of Members ages 0-6 with at least 90 days continuous enrollment in the same plan during the measurement period.
Adults (21+): Annual Dental Visits	0.325%	**Numerator**: Number of Members in the denominator who received any dental service (Current Dental Terminology (CDT) D0100-D9999), including dental encounters at

Performance Measure and Quality Metric	Withhold Percentage	Methodology
		SNCs. **Denominator:** Number of Members ages 21 and older with at least 90 days continuous enrollment in the same plan during the measurement period.
Adults (21+): Use of Preventive Services	.20%	**Numerator:** Number of Members in the denominator who received any preventive dental service (CDT D1000-D1999 or CPT Code 99188), including dental encounters at SNCs. **Denominator:** Number of Members ages 21 and older with at least 90 days continuous enrollment in the same plan during the measurement period
Children: Fluoride applications within reporting year in dental office	.15%	**Numerator:** Number of Members in the denominator who received at least one application of fluoride varnishes (CDT Codes D1206, D1208) rendered by an enrolled dental provider or dental encounter including at an SNC with ICD10: K036 or Z293. **Denominator**: Number of Members ages 0-20 with at least 90 days continuous enrollment in the same plan during the measurement period
Children: Fluoride application within reporting year in medical office (not weighted)	0.00%	**Numerator:** Number of members in the denominator who received at least one application of fluoride varnish (CPT Code 99188) rendered by an enrolled medical provider encounter including at an SNC. **Denominator**: Number of Members ages 0-20 with at least 90 days continuous enrollment in the same plan during the measurement period.

Performance Measure and Quality Metric	Withhold Percentage	Methodology
Children: Care Continuity Same Office for two or more consecutive years	.15%	**Numerator**: Number of Members in the denominator who received any dental service (CDT D0100-D9999), including dental encounters at SNCs, for two consecutive years at the same service office location. **Denominator:** Number of Members ages 0-20 with at least two years continuous enrollment in the same plan during the measurement period.
Children: Emergency Visits (Under Threshold)	.15%	**Numerator**: Number of Members in the denominator who had an ER visit.* **Denominator**: Number of Members ages 0-20 with at least 90 days continuous enrollment in the same plan during the measurement period. *The criteria would be all that have: Place of Service as "0" and at least one of the following codes: K08.21-K08.26, K08.0, K08.8, K05.32, K05.00, K05.10; K06.01; K06.02; K12.2; K04.6 – K04.7; K00.6, K01.1; M26.31; K06.3, A690; K005; K006; K007; K010; K011; K023; K0251; K0261; K0262; K0263; K027; K029; K030; K031; K032; K033; K034; K035; K036; K037; K0381; K0389; K039; K040; K041; K044; K045; K046; K047; K048; K0500; K0501; K0510; K0511; K0520; K0521; K0522; K0530; K0531; K0532; K055; K056; K060; K061; K062; K08101; K08102; K08103; K08104; K08109; K083; K08401; K08402; K08403; K08404; K08409; K08419; K08429; K08439; K08499; K0850; K0851; K0852; K08530; K08531; K0854; K0855; K0856; K0859; K088; K089; K120; K121; K122; K1230; K1231; K123; K1233; K1239; K130; K1321; K1322; K1323; K1329; K1370; K1379; K140; M2630; M2631; M2632; M2633; M2634; M2635; M2636; M2637; M2639; M264; M2650; M2651; M2652; M2653; M2654; M2655;

Performance Measure and Quality Metric	Withhold Percentage	Methodology
		M2669; M2679; M272; M273; M2761; M2762; M2763; M2769
Children: Emergency Visits Follow Up Services	.15%	**Numerator:** Number of Members in the denominator who received any dental service (Current Dental Terminology (CDT) D0100-D9999) including SNC encounters. **Denominator:** Number of Members ages 0-20 that have had a qualifying emergency room visit (related to dental emergency) with at least 90 days continuous enrollment in the same plan during the measurement period.
Adults: At least one fluoride application within reporting year	.15%	**Numerator:** Number of Members in the denominator who have had at least one application of fluoride varnish (CDT Codes D1206, D1208, CPT 99188) rendered by an enrolled dental or medical provider or dental encounter including at an SNC with ICD10: K036 or Z293. **Denominator:** Number of Members ages 21 and older with at least 90 days continuous enrollment in the same plan during the measurement period.
Children: Dental Office Follow Up Visit Following Medical Fluoride Application.	.15%	**Numerator:** Number of Members in the denominator who had an ADV in the following 180 days not including medical application of fluoride varnish (99188) including at SNCs. **Denominator:** Number of Members ages 0-20 with at least 90 days continuous enrollment in the same plan during the measurement period AND CPT for annual physical rendered by an enrolled medical provider encounter (CPT Codes 99385, 99386, 99387) including at an SNC. ICD10 Codes Z0000, Z0001, Z01411, Z01419.
Adults: Care	.15%	**Numerator**: Number of Members in the denominator who

Performance Measure and Quality Metric	Withhold Percentage	Methodology
Continuity Same Office for two or more consecutive years		received any dental service (CDT D0100-D9999), including encounters at SNCs, for two consecutive years at the same service office location. **Denominator:** Number of Members ages 21 and older with at least two years continuous enrollment in the same plan during the measurement period.
Adults: Emergency Visits (Under Threshold)	.15%	**Numerator**: Number of Members in the denominator who had ER visit.* **Denominator:** Number of Members ages 21 and older with at least 90 days of continuous enrollment in the same plan during the measurement period. *The criteria would be all that have: Place of Service as "0" and one of the following codes: K08.21-K08.26, K08.0, K08.8, K05.32, K05.00, K05.10; K06.01; K06.02; K12.2; K04.6 – K04.7; K00.6, K01.1; M26.31; K06.3 , A690; K005; K006; K007; K010 ; K011; K023; K0251; K0261; K0262; K0263; K027; K029; K030; K031; K032; K033; K034; K035; K036; K037; K0381; K0389; K039; K040; K041; K044; K045; K046; K047; K048; K0500; K0501; K0510; K0511; K0520; K0521; K0522; K0530; K0531; K0532; K055; K056; K060; K061; K062; K08101; K08102; K08103; K08104; K08109; K083; K08401; K08402; K08403; K08404; K08409; K08419; K08429; K08439; K08499; K0850; K0851; K0852; K08530; K08531; K0854; K0855; K0856; K0859; K088; K089; K120; K121; K122; K1230; K1231; K123; K1233; K1239; K130; K1321; K1322; K1323; K1329; K1370; K1379; K140; M2630; M2631; M2632; M2633; M2634; M2635; M2636; M2637; M2639; M264; M2650; M2651; M2652; M2653; M2654; M2655; M2656; M2657; M2659; M2660; M2661; M2662; M2663; M2669; M2679; M272; M273; M2761; M2762; M2763; M2769

Performance Measure and Quality Metric	Withhold Percentage	Methodology
Adults: Emergency Visits Follow Up Services	.15%	**Numerator**: Number of Members in the denominator who received any dental service (CDT D0100-D9999) including SNC dental encounters. **Denominator:** Number of Members in the numerator of the "Adults: Emergency Visits" measure
Adults: Primary Care Provider's Office Follow Up Services	.15%	**Numerator**: Number of Members in the denominator who had an ADV (CDT D0100-D9999 or CPT 99188), including dental encounters at SNCs, in an office or SNC within 180 days of a medical exams. **Denominator**: Number of Members ages 21 and older with at least 90 days continuous enrollment in the same plan during the measurement period who have had a qualifying primary care provider visit (CPT 99384-99386 and 99395).

2. PERFORMANCE MEASURES AND QUALITY METRICS

1. Contractor must submit all the necessary encounter data to capture the performance measures and quality metrics, and any other performance measures and quality metrics as determined by DHCS. The data must be submitted within six (6) months of the date of service.

2. DHCS will monitor the performance measures and quality metrics on a monthly basis. Contractor will be notified if DHCS identifies a problem with Contractor's performance or feels that Contractor is in jeopardy of not achieving the benchmark at their annual review.

3. PERFORMANCE AND QUALITY BENCHMARKS

DHCS will establish quality benchmarks for each performance measure and quality metric. DHCS will notify Contractor of approved quality benchmarks through All Plan Letters (APLs). Contractor shall meet or exceed the quality benchmark for each measure and/or any other performance measure established by DHCS. These performance measures, quality metrics and benchmarks will be reevaluated each year. DHCS will notify Contractor of new performance measures and quality metrics, or any changes to performance measures and quality metrics through APLs.

4. ONLINE POSTING OF UTILIZATION DATA

Upon completion of DHCS' annual evaluation of performance measures and quality metrics, DHCS will publish all results of Contractor's performance on the Medi-Cal Dental website **https://www.dhcs.ca.gov/services/Pages/MediCalDental.aspx)**.

EXHIBIT A7: UTILIZATION MANAGEMENT

1. UTILIZATION MANAGEMENT (UM) PROGRAM

Contractor shall develop, implement, and continuously update and improve, a UM program that ensures appropriate processes are used to review and approve the provision of medically necessary 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 the request of the Member.

4. Establish 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 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 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 and Oral Health Access Transformation Program (QIOHATP), including a process to integrate reports on review of the number and types of grievances and appeals, denials, deferrals, and modifications to the appropriate QIOHETP 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.

2. AUTHORIZATIONS AND REVIEW PROCEDURES

Contractor shall ensure that its 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). 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 approved, denied, deferred or modified referrals is made as specified in EXHIBIT A14: MEMBER SERVICES AND BENEFICIARY SUPPORT. There shall be a well-publicized grievances and appeals procedure 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 EXHIBIT A15: MEMBER GRIEVANCE AND APPEAL SYSTEM.

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 SECTION 20. AUDIT.

8. The requesting provider is notified of any decision to deny, approve, modify, defer 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 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 dental services when appropriate.

Upon request, Contractor shall provide a list of all services requiring prior authorizations.

3. 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 ten (10) business days from the receipt of the request. The decision may be deferred and the time limit extended an additional ten (10) business days only where the Member or the Member's provider requests an extension, or 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 fourteen (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 they disagree with the decision. If Contractor extends the fourteen (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), for requests in which a provider indicates, or 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, Contractor must make an expedited authorization decision and provide notice as expeditiously as the Member's health condition requires and no later than seventy-two (72) hours after receipt of the request for services. Contractor may extend the seventy-two (72) hour time period by up to fourteen (14) calendar days if the Member requests an extension, or if 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.

4. 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.

5. DELEGATING UM ACTIVITIES

Contractor may delegate UM activities. If Contractor delegates these activities, Contractor shall comply with SECTION 6. SUBCONTRACTOR QUALITY IMPROVEMENT ACTIVITIES.

6. PROGRAM INTEGRITY AND COMPLIANCE PROGRAM

Contractor must establish administrative and management policies and procedures which are designed to prevent and detect Fraud, Waste, and Abuse. In furtherance of this goal, Contractor must establish a Compliance program, a Fraud, Waste, and Abuse prevention program, and other program integrity processes, as set forth in this Exhibit, EXHIBIT A7: UTILIZATION MANAGEMENT. In establishing these policies, procedures, and programs, Contractor must meet the requirements of 42 CFR section 438.608.

While Contractor may contract with entities to support Contractor on compliance activities (such as training and auditing), Contractors must ensure that all Subcontractors have a robust program integrity and compliance program in place. This requirement may be fulfilled by the Contractor maintaining all program integrity and compliance program functions on behalf of Subcontractor.

7. COMPLIANCE PROGRAM

Contractor must have a compliance program that includes, at a minimum, the following elements:

1. Compliance plan which:

    a. Outlines the key elements of the compliance program;

    b. Includes reference to the standards of conduct;

c. Allows the compliance program to act independently of operational and program areas without fear of repercussions for uncovering deficiencies or noncompliance;

d. Details how it will implement and maintain elements of the compliance program;

e. Includes the compliance reporting structure and positions of key personnel involved in ensuring compliance, including the compliance officer;

f. References the delegation reporting and compliance plan

g. References policies and procedures operationalizing the compliance program;

h. Is reviewed and approved by the board of director's compliance and oversight committee routinely, but not less than biennially; and

i. Is publicly posted on Contractor's website.

2. Standard of conduct or code of conduct should clearly articulate Contractor's commitment to comply with all applicable requirements and standards under this Contract, and all applicable federal and State requirements. It must describe the organizational expectations that all employees act ethically and have a responsibility in ensuring compliance. Standard of conduct must be approved by Contractor's full board of directors as it is a foundational statement of governing principles.

3. Written policies and procedures which address the following:

   a. Detail how elements of the compliance program are operationalized;

   b. Articulate how Contractor will ensure that all Network Providers, and Subcontractors, comply with all applicable terms and conditions of the Contract (See also, SECTION 6. FISCAL VIABILITY OF NETWORK PROVIDERS AND SUBCONTRACTORS); and

   c. Are reviewed at least annually. Contractor must update the policies and procedures to incorporate changes in applicable laws, regulations, and requirements.

4. A delegation reporting and compliance plan as described in SECTION 14.8. DELEGATION REPORTING AND COMPLIANCE PLAN and ATTACHMENT 14.6: DELEGATION REPORTING

AND COMPLIANCE PLAN;

5. The designation of a compliance officer who is responsible for developing, implementing, and ensuring compliance with the requirements and standards under the Contract and who reports directly to the chief executive officer and the board of directors. Contractor's policies and procedures must include the criteria for selecting a compliance officer and a job description, including responsibilities and the authority of this position. The compliance officer must be a full-time employee and must be independent, which means they must not serve in both a compliance and operational role, for example, when the compliance officer is the chief operating officer, finance officer or general counsel.

6. The establishment of a regulatory compliance and oversight committee on the board of directors and at the senior management level charged with overseeing Contractor's compliance program and compliance with the requirements under this Contract. Contractor's policies and procedures must include the criteria for selecting members. The committee is charged with reviewing the compliance plan on an annual basis. The committee is responsible for convening at least on a quarterly basis to enable oversight activities such as implementation and monitoring of corrective actions.

7. A system for training and educating the compliance officer, senior management, and employees on federal and State standards and requirements of this Contract. Trainings should include standards of conduct, compliance plan, and compliance policies and procedures Compliance trainings should be verified such as through a certification or attestation upon training completion and review of the standard of conduct, compliance program, and compliance policies and procedures. Contractor must ensure that training for the compliance officer, senior management, and employees on the compliance program is completed within 90 days of employment and annually thereafter.

8. A system for employees to receive training on policies and procedures related to compliance for specific job functions including but not limited to:

    a. Compliance officer, senior management, and employees training and education on the overall compliance program, fraud, waste, and abuse, and code of conduct in accordance with SECTION 6. PROGRAM INTEGRITY AND COMPLIANCE PROGRAM;

    b. Network Providers completion of required initial and ongoing Network Provider training within the established timeframes in accordance with this contract; and

    c. Member Services staff completion of required training and include diversity, equity and inclusion training in accordance with SECTION 11. DIVERSITY, EQUITY AND

INCLUSION TRAINING

9. Effective lines of communication between the compliance officer and employees. For example, Contractor must establish a consistent process for distributing and communicating new regulations, regulatory changes, or changes relevant to this Contract. Contractor will communicate this process to all Subcontractors and Network Providers, as applicable. Lines of communication must be accessible to all employees and allow compliance issues to be reported including a method for anonymous and confidential good faith reporting of potential compliance issues as they are identified.

10. Enforcement of standards through well-publicized disciplinary guidelines. This includes, but is not limited to: establishment and implementation of disciplinary policies and procedures that reflect clear and specific disciplinary standards as well as Contractor's expectation for reporting of issues related to noncompliance or illegality; training expectations and disciplinary or enforcement standards when noncompliant activity is found.

    a. To demonstrate that disciplinary guidelines are enforced, Contractor must maintain records of disciplinary actions for a period of 10 years at a minimum, including date of and description of violation, date of investigation, findings and date and description disciplinary action.

11. Contractor must develop and maintain effective systems for routine monitoring and auditing, and identification of compliance risks including but not limited to:

    a. Dedicated staff for routine internal monitoring and auditing of compliance risks;

    b. Methods and tools for assessing activities for regulatory compliance. This includes evaluating a function and trending activity over a period of time to assess patterns and variations;

    c. Routine and periodic reporting of activity to compliance and oversight committee of the board; and

    d. Unannounced audits of Subcontractors to assess the compliance with requirements set forth in this Contract as relevant to delegated functions.

8. FRAUD PREVENTION PROGRAM

Contractor must have a Fraud prevention program that at a minimum sets forth policies and procedures

for the elements identified in this section.

8.1. FRAUD PREVENTION OFFICER

Contractor must designate a fraud prevention officer who is responsible for developing, implementing, and ensuring compliance with Contractor's Fraud prevention program and who reports directly to the chief executive officer and the board of directors. The fraud prevention officer must attend and participate in DHCS' quarterly program integrity meetings, as scheduled. The same individual may serve as both the compliance officer and the fraud prevention officer.

8.2. NOTIFICATION OF CHANGES IN MEMBER'S CIRCUMSTANCES

Information about changes in a Member's circumstances that may affect the Member's eligibility including changes in the Member's residence, income, insurance status, and death (42 CFR § 438.608(a)(3)). This notification will be in a form and manner specified by DHCS through APL, or other similar instructions.

8.3. METHOD TO VERIFY SERVICES RECEIVED

Contractor must have a method to verify, by sampling or other methods, confirming that services that have been represented to have been delivered by Network Providers were received by Members. (42 CFR § 438.608(a)(5)). Contractor must provide proof of compliance with this requirement when requested by DHCS, in a form and manner specified by DHCS through APL, or other similar instruction.

8.4. CONTRACTOR'S REPORTING OBLIGATIONS

Investigate, and report all Fraud, Waste, and Abuse activities that Contractor identifies to DHCS' Program Integrity Unit (PIU), in a manner prescribed by PIU, as follows:

1. Preliminary Fraud, Waste, and Abuse Reports

   Contractor must file a preliminary report with DHCS' PIU detailing any suspected Fraud, Waste, or Abuse identified by or reported to Contractor, its Subcontractors, and/or its Network Providers within ten Working Days of Contractor's discovery or notice of such Fraud, Waste, or Abuse. Contractor must submit a preliminary report in accordance with requirements set forth in an APL or other similar instructions. Subsequent to the filing of the preliminary report, Contractor must promptly conduct a complete investigation of all reported or suspected Fraud, Waste, and Abuse activities.

2. Completed Investigation Report

   Investigation (including both Contractor-initiated and DHCS-initiated referrals), Contractor must

submit a completed report to DHCS' PIU. This report must include Contractor's findings, actions taken, and include all documentation necessary to support any action taken by Contractor, and any additional documentation as requested by DHCS or other state and federal agencies.

3. Quarterly Fraud, Waste, Abuse Status Report

   Contractor must submit a quarterly report to DHCS' PIU on all Fraud, Waste, and Abuse investigative activities ten Working Days after the close of every calendar quarter. The quarterly report must contain the status of all preliminary, active, and completed investigations and must include both Contractor-initiated and DHCS-initiated referrals. In addition to quarterly reports, Contractor must provide updates and available documentation as DHCS may request from time to time.

4. Manner of Report Submission

   Reports in a manner prescribed by DHCS' PIU. The required report must include but not be limited to the preliminary Fraud report, the completed investigation report, and the quarterly status report, including all supporting documents, and any additional documents requested by DHCS, in a form and manner specified by DHCS through APL, or other similar instructions.

5. Contractor's Obligation to Investigate State, Federal, and Other Medi-Cal Managed Care Plans' Referrals of Fraud, Waste, and Abuse.

   DHCS may, from time to time, share with Contractor relevant Fraud, Waste, and Abuse referrals received from State and federal agencies and other Medi-Cal managed care plans. Contractor may also receive Fraud, Waste, and Abuse referrals directly from other federal agencies, State agencies (other than DHCS), and Medi-Cal managed care plans.

   Contractor must conduct a complete investigation of all Fraud, Waste, and Abuse referrals received from DHCS, other State and federal agencies, and other Medi-Cal managed care plans, relating to Contractor's Subcontractors, and Network Providers. Contractor must submit a completed investigation report and a quarterly status report, as set forth above in this Exhibit, SECTION 2. CONTRACTOR'S FINANCIAL REPORTING OBLIGATIONS, in connection with all DHCS, State and federal agency, and Medi-Cal managed care plan referrals of Fraud, Waste, and Abuse.

6. Confidentiality

   Contractor acknowledges that information shared by DHCS, other State and federal agencies,

and other Medi-Cal managed care plans in connection with any Fraud, Waste, or Abuse referral must be considered confidential, until formal criminal proceedings are made public. Contractor further acknowledges that it is receiving this Confidential Information as a DHCS business associate in order to facilitate Contractor's contractual obligations to maintain a Fraud, Waste, and Abuse prevention program. Contractor must receive and maintain this Confidential Information in its capacity as a Medi-Cal managed care plan and will use the Confidential Information only for conducting an investigation into any potential Fraud, Waste, or Abuse activities and in furtherance of any other program integrity activities.

In the event Contractor is required to share this Confidential Information with a Subcontractor or Network Provider, Contractor must ensure that Subcontractor and Network Provider acknowledge that such information must be kept confidential by Subcontractor and Network Provider, and a similar provision of confidentiality must be included in all Subcontractor Agreements and Network Provider Agreements.

9. DISCLOSURES

In accordance with 42 CFR section 438.608(c), Contractor, and a its Subcontractors, must:

1. Provide written disclosure of any prohibited affiliation under 42 CFR section 438.610;

2. Provide written disclosures of information on ownership and control as required under 42 CFR section 455.104; and

3. Report and return any Overpayment to DHCS within 60 calendar days of when it has identified any Capitation Payments or other payments it has received or paid in excess of the amounts specified in this Contract.

10. TREATMENT OF OVERPAYMENT RECOVERIES

1. Retention, Reporting, and Payment of Recoveries

   Contractor must comply with guidelines issued by DHCS pertaining to retention policies for the treatment of recoveries of all Overpayments from Contractor to a Provider, including for the treatment of recoveries of Overpayments due to Fraud, Waste, or Abuse. Contractor must also comply with the process, timeframes, and documentation required for reporting and paying to DHCS the recovery of all Overpayments, as set forth in APL 22-003E. In addition, Contractor must comply with this Contract, and all applicable State and federal law regarding Overpayment recoveries, including 42 CFR sections 438.608(a)(2) and (d).

2. Federal False Claims Act Compliance and Support

    a. Employee Education about False Claims Recovery

    Contractor must provide to all its employees, Subcontractors, and Network Providers written policies containing detailed information about the False Claims Act and other federal and State laws described in 42 USC section 1396a(a)(68), including information about rights of employees to be protected as whistleblowers. (See also 42 CFR §438.608(a)(6).)

    Upon request by DHCS, Contractor must demonstrate compliance with this SECTION 10. TREATMENT OF OVERPAYMENT RECOVERIES Subprovision 2.a (Employee Education about False Claims Recovery), which may include providing DHCS with copies of Contractor's applicable written policies and procedures and any relevant employee handbook excerpts.

    b. Cooperation with the Office of the Attorney General, DMFEA, and the US DOJ Investigations and Prosecutions

    Contractor must fully cooperate in any investigation or prosecution conducted by the Office of the Attorney General, DMFEA and the US DOJ. Contractor’s cooperation must include, but is not limited to, providing upon request, information and access to records. Contractor is also responsible for making their staff available for in-person interviews, consultation, grand jury proceedings, pre-trial conference, depositions, and hearings at DHCS headquarters in Sacramento.

3. Money Recovered from State Action Belongs to the State

    In the event that DHCS receives a monetary recovery from the Office of the Attorney General, DMFEA, or the US DOJ, as a result of DMFEA’s or US DOJ’s prosecution of a Subcontractor, or Network Provider under the California False Claims Act (Government Code § 12650 et seq.), the Federal False Claims Act (31 USC § 3729 et seq.), or any other applicable laws, the entirety of such monetary recovery belongs exclusively to DHCS, and Contractor waives any claim to any portion of the recovery, except as determined by DHCS in its sole discretion.

4. Payment to Contractor is from Government Fund

    Medi-Cal payments to Contractor, Subcontractors, Network Providers, and Providers are made from federal and State government funds. DHCS retains the right to recover Overpayments made

to Contractor, Subcontractors or Network Providers, and/or Providers of Medi-Cal services as set forth in part in Exhibit B, (Recovery of Amounts Paid to Contractor). In addition to DHCS' recovery rights, DMFEA and US DOJ may prosecute any act of health care Fraud involving such government funds under the California False Claims Act (Government Code, § 12650 et seq.), the Federal False Claims Act (31 USC § 3729 et seq.), or any other applicable laws.

5. Contractor's Settlements with Subcontractors and Network Providers do not bind DHCS, DMFEA, or the US DOJ

   Any settlement or resolution of a disputed matter involving Fraud, Waste, or Abuse between Contractor and its Subcontractor, or Network Provider must include a written provision that provides notice to the Subcontractor, or Network Provider that the settlement and/or resolution is not binding on DHCS, DMFEA, or the US DOJ and does not preclude DHCS, DMFEA, or the US DOJ from taking further action against Contractor or its Subcontractor, or Network Provider.

EXHIBIT A8: PROVIDER NETWORK

1. NETWORK CAPACITY

Contractor shall maintain a Provider Network adequate to serve sixty percent (60%) of all Eligible Beneficiaries within Contractor's Service Area and provide the full scope of dental benefits. Contractor will increase the capacity of the Network as necessary to accommodate enrollment growth beyond the sixty percent (60%). However, after the first twelve (12) months of operation, if Enrollments do not achieve seventy-five percent (75%) of the required Network capacity, Contractor's total Network capacity requirement may be renegotiated.

2. NETWORK COMPOSITION

Contractor shall ensure and monitor an appropriate Provider Network within its Service Area in compliance with W&I Code section 14197, and if necessary to ensure compliance with Network adequacy requirements in this Contract, attempt to contract with Providers in adjoining counties outside of Contractor's Service Area In addition, Contractor shall ensure and monitor Indian Health Care Providers, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Freestanding Birthing Centers (FBCs), where available. Contractor shall submit assurances to DHCS regarding its Network composition in accordance with 42 CFR section 438.207.

3. PROVIDER TO MEMBER RATIOS

1. Contractor shall ensure that its Network continuously satisfies the following full-time equivalent Network Provider and Member ratios:

    a. Primary Care Dentists 1:2,000

    b. Total Network Dentists 1:1,200

2. Contractor shall remain in compliance 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.

3. 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.

4. 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 twenty-four (24) hours a day, seven (7) days a week.

5. SPECIALISTS

Contractor shall maintain an adequate Network that includes adult and pediatric Specialists, and at a minimum, core Specialists as described in Welfare and Institutions Code, Section 14197(h)(2)

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 Contractor’s provider network. 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.

6. 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 Contractor has a DHCS approved alternative time and distance standard, pursuant to Welfare & Institutions Code Section 14197(e).

7. NETWORK PROVIDER AVAILABILITY

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.

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

8. PROVIDER NETWORK REPORTS

Contractor shall submit to DHCS monthly in a format specified by DHCS in EXHIBIT A19: DELIVERABLE TEMPLATES, 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.

3. At the time of a Significant Change, as defined in this Contract and set forth in 42 CFR 438.207, to the Network affecting Provider capacity and services, the contractor shall include in the report any additional information concerning:

    a. Change in services or benefits;

    b. The composition of, or the payments to, it's Network; or

    c. Enrollment of a new population.

4. Contractor shall participate annually in the submission to DHCS of its Provider Network composition report to demonstrate its capacity to serve the current and expected membership in its Service Area in accordance with State standards for access and timeliness of care, 42 CFR 438.207(b),

9. PLAN PROVIDER NETWORK

Contractor must comply with the Provider Screening/Enrollment requirements contained in CMS Final Rule 2390-F, dated May 6, 2016 (https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf) and Credentialing/Recredentialing requirements contained in 42 CFR 438.214 and 438.602 (https://www.ecfr.gov/cgi-bin/textidx?SID=755076fcbadfbe6a02197ec96e0f7e16&mc=true&node=pt42.4.438&rgn=div5#se42.4.438_1214) and DHCS policy requirements as described in APL 18-004. Providers that are unable to lawfully enroll or remained enrolled in in a Dental Managed Care plan are referred to as Excluded Providers.

Contractor shall submit to DHCS biannually or upon DHCS' request, in a format specified in EXHIBIT A19: DELIVERABLE TEMPLATES, a report containing the names of all Subcontractors including 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 Contractor's provider network responsibilities, 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 the request of the Member.

3. If Contractor's provider network is unable to provide necessary services, covered under the contract, to a particular Member, Contractor must adequately and timely cover these services out- of-network for the Member, for as long as Contractor's provider network is unable to provide them.

4. Require out-of-network providers to coordinate with Contractor for payment and ensure 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

10. 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.

11. NETWORK PROVIDER AGREEMENTS AND SUBCONTRACTOR AGREEMENTS

Contractor may enter into Network Provider Agreements and Subcontractor Agreements with other entities in order to fulfill the obligations of the Contract. Contractor shall maintain policies and

procedures, approved by DHCS, to ensure that Network Providers and Subcontractors fully comply with all terms and conditions of this Contract. Contractor shall evaluate the prospective Network Providers and Subcontractor's ability to perform the contracted services, shall oversee and remain responsible and accountable for any functions and responsibilities delegated and shall meet the contracting requirements as stated in 42 CFR 438.230(b)(1), (c)(1)(i)-(iv), (c)(2), (c)(3), Title 22 CCR Section 53867, and this Contract.

11.1. LAWS AND REGULATIONS

All Network Provider Agreements and Subcontractor Agreements shall be in writing and in accordance with the requirements of the 42 CFR 438.230(c)(1)(i)-(iv), Knox-Keene Health Care Services Plan Act of 1975, Health and Safety Code Section 1340 et seq.; Title 28 CCR Section 1300 et seq.; W&I Code Section 14200 et seq.; Title 22 CCR Section 53800 et seq.; and other applicable federal and State laws and regulations.

11.2. NETWORK PROVIDER AGREEMENT REQUIREMENTS

Network Provider Agreements must contain the following provisions:

a. Specification of the Covered Services to be ordered, referred, or rendered;

b. Specification of the term of the agreement, including the beginning and ending dates as well as methods of extension, renegotiation, phaseout, and termination;

c. Full disclosure of the method and amount of compensation or other consideration to be received by Network Provider;

d. Specification that the agreement shall be governed by and construed in accordance with all applicable laws and regulations governing this Contract, including but not limited to, Knox-Keene Health Care Services Plan Act of 1975, Health and Safety Code Section 1340 *et seq*. (unless expressly excluded under this Contract); Title 28 CCR Section 1300.43 *et seq.*; W&I Code Sections 14000 and 14200 *et seq.*; and Title 22 CCR Sections 53800 *et seq.*;

e. Network Providers will comply with all applicable requirements of the DHCS Medi-Cal Dental

Managed Care Program, including but not limited to, all applicable federal and State Medicaid and Medi-Cal laws, regulations, sub-regulatory guidance, APLs, and provisions of this Contract;

f. Network Providers will submit to Contractor, either directly or through a Subcontractor as applicable, complete, accurate, and timely Encounter Data and Provider Data, and any other reports or data as needed by Contractor, in order for Contractor to meet its data reporting requirements to DHCS;

g. Network Providers will maintain and make available to DHCS, upon request, copies of all contracts it enters into related to ordering, referring, or rendering Covered Services under the Network Provider Agreement, and will ensure that all such contracts are in writing;

h. Network Providers will make all of its premises, facilities, equipment, books, records, contracts, and computer and other electronic systems pertaining to the Covered Services ordered, referred, or rendered under the terms of the Network Provider Agreement, available for the purpose of an audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in SECTION 22. INSPECTION RIGHTS:

    1. In accordance with inspections and audits, as directed by DHCS, CMS, DHHS Inspector General, the Comptroller General, Department of Justice (DOJ), DMHC, or their designees; and

    2. At all reasonable times at a Network Provider's place of business or at such other mutually agreeable location in California.

i. Network Providers will maintain all of its books and records, including Encounter Data, in accordance with good business practices and generally accepted accounting principles for a term of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later;

j. Network Providers will timely gather, preserve and provide to DHCS, CMS, Attorney General's Division of Medi-Cal Fraud and Elder Abuse (DMFEA), and any authorized State or federal regulatory agencies, any records in Network Provider's possession, in accordance with SECTION 27. RECORDS RELATED TO RECOVERY FOR LITIGATION;

k. Network Providers will assist Contractor, or if applicable a Subcontractor, in the transfer of a Member's care in accordance with SECTION 17. PHASEOUT REQUIREMENTS, in the event of Contract termination, or in the event of termination of the Network Provider for any reason;

l. Specification that the Network Provider Agreement will be terminated, or subject to other remedies, if DHCS or Contractor determine that the Network Provider has not performed satisfactorily;

m. Network Providers will hold harmless both the State and Members in the event Contractor or, if applicable a Subcontractor, cannot or will not pay for Covered Services ordered, referred, or rendered by Network Provider pursuant to the Network Provider Agreement;

n. Network Providers will not bill Members for Medi-Cal Covered Services;

o. Contractor must inform Network Providers of prospective requirements added by State or federal law or DHCS related to this Contract that impact obligations undertaken through the Network Provider Agreement before the requirement would be effective, and agreement by Network Providers to comply with the new requirements within 30 calendar days of the effective date, unless otherwise instructed by DHCS;

p. Network Providers to ensure that cultural competency, sensitivity, oral health access, and training is provided for employees and staff at key points of contact with Members;

q. Network Providers to provide interpreter services for Members and comply with language assistance standards developed pursuant to Health and Safety Code Section 1367.04;

r. Network Providers must notify Contractor, and Contractor's Subcontractor, within ten (10)

Working Days of any suspected Fraud, Waste, or Abuse and a provision that allows Contractor to share such information with DHCS in accordance with SECTION 28. FRAUD, WASTE AND ABUSE, Section 3, Fraud Waste and Abuse Reporting;

s. Network Providers must:

1. Report to Contractor or Contractor's Subcontractor when it has received an Overpayment;

2. Return the Overpayment to Contractor or Contractor's Subcontractor within 60 calendar days of the date the Overpayment was identified; and

3. Notify Contractor or Contractor's Subcontractor in writing, the reason for the Overpayment in accordance with SECTION 28. FRAUD, WASTE AND ABUSE, Section 3, Subsection 4, and 42 CFR Section 438.608(d).

t. Confirmation of a Network Provider's right to all protections afforded them under the Health Care Providers' Bill of Rights, including, but not limited to a Network Provider's right to access Contractor's dispute resolution mechanism and submit a grievance pursuant to Health and Safety Code Section 1367(h)(1).

u. Network Provider must execute the California Health and Human Services Data Exchange Framework data sharing agreement pursuant to Health and Safety Code Section 130290.

11.3. SUBCONTRACTOR AND DOWNSTREAM SUBCONTRACTOR AGREEMENT REQUIREMENTS

Subcontractor Agreements and Downstream Subcontractor Agreements must contain the following provisions, as applicable to the specific obligations and functions that Contractor delegates in the Subcontractor Agreement or that the Subcontractor or Downstream Subcontractor delegates in the Downstream Subcontractor Agreement:

a. Specification of Contractor's obligations and functions undertaken by the Subcontractor or Downstream Subcontractor;

b. Specification of the term of the agreement, including the beginning and ending dates as well as methods of extension, renegotiation, phaseout, and termination;

c. Full disclosure of the method and amount of compensation or other consideration to be received by Subcontractor or Downstream Subcontractor per unit of service;

d. Specification that the Subcontractor Agreement and amendments thereto shall become effective only as set forth in EXHIBIT A8: PROVIDER NETWORK;

e. Subcontractor's assignment or delegation of the Subcontractor Agreement to any Downstream Subcontractor is void unless prior written approval is obtained from DHCS;

f. Downstream Subcontractor's assignment or delegation of an obligation or responsibility under a Downstream Subcontractor Agreement to any Downstream Subcontractor is void unless prior written approval is obtained from DHCS;

g. Specification that the Subcontractor Agreement or Downstream Subcontractor Agreement shall be governed by and construed in accordance with all applicable laws and regulations governing this Contract, including but not limited to 42 CFR Section 438.230; Knox-Keene Health Care Services Plan Act of 1975, Health and Safety Code Section 1340 *et seq*. (unless otherwise expressly excluded under this Contract); Title 28 CCR Section 1300.43 *et seq.*; W&I Code Section 14000 *et seq.*; and Title 22 CCR Section 53800 *et seq.*;

h. Subcontractor and Downstream Subcontractors must comply with all applicable requirements of the DHCS Dental Managed Care Program, pertaining to the obligations and functions undertaken pursuant to the Subcontractor Agreement or Downstream Subcontractor Agreement, including but not limited to, all applicable Medicaid and Medi-Cal laws, regulations, sub-regulatory guidance, APLs, and the provisions of this Contract;

i. Language comparable to SECTION 8. NON-CONTRACTING EMERGENCY SERVICE PROVIDERS for those Subcontractors or Downstream Subcontractors obligated to reimburse Providers of Emergency Services;

j. Subcontractor and Downstream Subcontractors will submit to Contractor, either directly or through a Subcontractor as applicable, complete, accurate, and timely Encounter Data and Provider Data, and any other reports and data as needed by Contractor, in order for Contractor to meet its reporting requirements to DHCS;

k. Subcontractor and Downstream Subcontractors will comply with all monitoring provisions of this Contract and any monitoring requests by DHCS;

l. Subcontractor and Downstream Subcontractors will maintain and make available to DHCS, upon request, copies of all contracts it enters into related to the performance of the obligations and functions it undertakes pursuant to the Subcontractor Agreement, and to ensure that such contracts are in writing;

m. Subcontractor and Downstream Subcontractors must make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the obligations and functions undertaken pursuant to the Subcontractor Agreement or Downstream Subcontractor Agreement, available for the purpose of an audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in SECTION 20. AUDIT and SECTION 22. INSPECTION RIGHTS:

    1. In accordance with inspections and audits, as directed by DHCS, CMS, DHHS Inspector General, the Comptroller General, DOJ, DMHC, or their designees; and

    2. At all reasonable times at Subcontractor's or Downstream Subcontractor's place of business or at such other mutually agreeable location in California.

n. Subcontractor and Downstream Subcontractors will maintain all of its books and records, including Encounter data, in accordance with good business practices and generally accepted accounting principles for a term of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later;

o. Subcontractor and Downstream Subcontractors will timely gather, preserve, and provide

to DHCS, CMS, DMFEA, and any authorized State or federal regulatory agencies, any records in Subcontractor's possession, in accordance with SECTION 27. RECORDS RELATED TO RECOVERY FOR LITIGATION;

p. Subcontractor and Downstream Subcontractors will assist Contractor in the transfer of a Member's care as needed, and in accordance with SECTION 17. PHASEOUT REQUIREMENTS in the event of Contract termination for any reason; or in the event of termination of the Subcontractor Agreement or Downstream Subcontractor Agreement for any reason;

q. Subcontractor and Downstream Subcontractors will notify DHCS in the event the Subcontractor Agreement or any Downstream Subcontractor Agreement is amended or terminated for any reason;

r. Subcontractor and Downstream Subcontractors will hold harmless both the State and Members in the event Contractor, or another Subcontractor or Downstream Subcontractor as applicable, cannot or will not pay for the obligations and functions undertaken pursuant to the Subcontractor Agreement or Downstream Subcontractor Agreement;

s. Subcontractor and Downstream Subcontractors will participate and cooperate in Contractor's SECTION 4. QUALITY IMPROVEMENT AND ORAL HEALTH ACCESS TRANSFORMATION PROGRAM (QIOHATP);

t. If Subcontractor or Downstream Subcontractors takes on Quality Improvement activities, the Subcontractor Agreement or Downstream Subcontractor Agreement shall include those provisions stipulated in SECTION 6. SUBCONTRACTOR QUALITY IMPROVEMENT ACTIVITIES;

u. To the extent Subcontractor or Downstream Subcontractor undertakes coordination of care obligations and functions for Members, an agreement to share with Subcontractor and Downstream Subcontractor any utilization data that DHCS has provided to Contractor, and agreement by the Subcontractor~~'s~~ and Downstream Subcontractors to receive the utilization data provided and use it solely for the purpose of Member Care Coordination;

v. Contractor will inform Subcontractor of prospective requirements added by federal or State law or DHCS related to this Contract that impact obligations and functions undertaken pursuant to the Subcontractor Agreement before the requirement is effective, and Subcontractor's agreement to comply with the new requirements within 30 calendar days of the effective date, unless otherwise instructed by DHCS;

w. Subcontractor or Downstream Subcontractors must inform the Downstream Subcontractor taking on delegated functions of prospective requirements added by federal or State law or DHCS related to this Contract that impact obligations and functions undertaken pursuant to the Downstream Subcontractor Agreement before the requirement is effective, and the agreement of the Downstream Subcontractor taking on delegated functions to comply with the new requirements within 30 calendar days of the effective date, unless otherwise instructed by DHCS;

x. Subcontractor and Downstream Subcontractors will ensure that cultural competency, sensitivity, oral health access, and diversity training is provided for Subcontractor's and Downstream Subcontractor's staff at key points of contact with Members;

y. Subcontractor and Downstream Subcontractors, to the extent Subcontractor communicates with Members, will provide interpreter services for Members, and to comply with language assistance standards developed pursuant to Health and Safety Code Section 1367.04;

z. Subcontractor and Downstream Subcontractors will notify Contractor within ten (10) Working Days of any suspected Fraud, Waste, or Abuse and a provision that allows Contractor to share such information with DHCS in accordance with SECTION 28. FRAUD, WASTE AND ABUSE, Section 3, Fraud Waste and Abuse Reporting;

aa. Subcontractor will:

1. Report to Contractor or through the Subcontractor or Downstream Subcontractor, as applicable, when it has received an Overpayment;

2. Return the Overpayment to Contractor within 60 calendar days after the date the Overpayment was identified; and

3. Notify Contractor in writing, the reason for the Overpayment (42 CFR Section 438.608(d)(2));

bb. Subcontractor and Downstream Subcontractors will perform the obligations and functions of Contractor undertaken pursuant to the Subcontractor Agreement or Downstream Subcontractor Agreement, including but not limited to reporting responsibilities, in compliance with Contractor's obligations under this Contract in accordance with 42 CFR Section 438.230(c)(1)(ii); and

cc. Express agreement and acknowledgement by Subcontractor and Downstream Subcontractors that DHCS is a direct beneficiary of the Subcontractor Agreement or Downstream Subcontractor Agreement with respect to all obligations and functions undertaken pursuant to that Subcontractor Agreement or Downstream Subcontractor Agreement, and that DHCS may directly enforce any and all provisions of the Subcontractor Agreement or Downstream Subcontractor Agreement.

dd. Subcontractors and Downstream Subcontractors must execute the California Health and Human Services Data Exchange Framework data sharing agreement, if applicable, pursuant to Health and Safety Code Section 130290.

ee. Specification of Subcontractors', including Downstream Subcontractors', Medical Loss Ratio (MLR) reporting and remittance obligations pursuant to 42 CFR sections 438.8 and 438.230(c) and Paragraph 11 of the 1915(b) CalAIM Special Terms and Conditions (STCs), which include, but are not limited to, the requirements in:

1. Exhibit A3, Section 5.1 (Medical Loss Ratio) for the CalAIM 1915(b) STC downstream requirements and four-part test;

2. Exhibit A3, Section 5.2 (Medical Loss Ratio) for the MLR Experience Defined;

3. Exhibit A3, Sections 5.3 and 5.4 (Medical Loss Ratio) for the Materiality Threshold;

4. Exhibit A3, Section 5.5 (Medical Loss Ratio) for the MLR numerator and incurred claims for Subcontractors and Downstream Subcontractors;

5. Exhibit A3, Section 5.5.a.ii.3 (Medical Loss Ratio) for remittances received by Subcontractors and Downstream Subcontractors must be deducted from incurred claims;

6. Exhibit A3, Section 5.5.a.v.3 (Medical Loss Ratio) for remittances paid by Subcontractors and Downstream Subcontractors must be excluded from incurred claims;

7. Exhibit A3, section 5.6 (Medical Loss Ratio) for MLR denominator;

8. Exhibit A3, Section 5.7 (Medical Loss Ratio) for Subcontractor and Downstream Subcontractor allocation of expenses;

9. Exhibit A3, Section 5.8 (Medical Loss Ratio) for Subcontractor and Downstream Subcontractor credibility adjustments;

10. Exhibit A3, Section 5.9 (Medical Loss Ratio) for materiality threshold;

11. Exhibit A3, Section 5.10 (Medical Loss Ratio) for Subcontractor and Downstream Subcontractor MLR reporting at Subcontractor or Downstream Subcontractor arrangement level by county or rating region;

12. Exhibit A3, Section 5.11 (Medical Loss Ratio) for general MLR reporting requirement imposed on Subcontractors and Downstream Subcontractors;

13. Exhibit A3, Section 5.11.d (Medical Loss Ratio) for Subcontractor and Downstream Subcontractor reporting requirements on downstream entities that accept financial

risk;

14. Exhibit A3, Section 5.11.e (Medical Loss Ratio) for Subcontractor and Downstream Subcontractor MLR submission accuracy attestation;

15. Exhibit A3, Section 5.11.f (Medical Loss Ratio) for requirements for Subcontractor and Downstream MLR submissions and oversight requirements;

16. Exhibit A3, Section 5.13 (Medical Loss Ratio) for newer experience exemptions for Subcontractors and Downstream Subcontractors;

17. Exhibit A3, Section 5.15 (Medical Loss Ratio) for Subcontractor and Downstream Subcontractor re-reporting requirements following a retroactive change to the Capitation Payments for a MLR reporting year.

18. Exhibit A3, Section 5.16 (Medical Loss Ratio) for Subcontractor and Downstream Subcontractor remittance requirements; and

19. Exhibit A3, Section 5.17 (Medical Loss Ratio) for Subcontractor and Downstream Subcontractor audit and record retention requirements.

11.4. PUBLIC RECORDS

To the extent DHCS receives Contractor’s Network Provider Agreements, Subcontractor Agreements, or Downstream Subcontractor Agreements, these agreements and all information received in accordance with these agreements will be public records on file with DHCS, except as specifically exempted in statute. The names of the officers and owners of the Network Provider, Subcontractor or Downstream Subcontractor; stockholders owning more than five percent (5%) of the stock issued by the Network Provider, Subcontractor or Downstream Subcontractor; and major creditors holding more than five percent (5%) of the debt of the Network Provider, Subcontractor, or Downstream Subcontractor must be attached to the Network Provider Agreement, Subcontractor Agreement, or Downstream Subcontractor Agreement at the time that agreement is submitted to DHCS.

12. REVIEW OF SUBCONTRACTS

DHCS reserves the right to request and review any subcontracts between Contractor and the subcontracting party. At the discretion of DHCS, copies of subcontracts and all credentialing or revalidating materials may be requested for review.

13. SUBCONTRACTS WITH FEDERALLY QUALIFIED HEALTH CENTERS, RURAL HEALTH CLINICS AND INDIAN HEALTH CARE PROVIDERS (FQHC/RHC/IHCP)

Contractor shall actively conduct outreach to subcontract with Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) and Indian Health Care Providers (IHCPs) in the service area and include them as part of Contractor's provider network.

Subcontracts with FQHCs and ICHPs shall also meet subcontract requirements of Provision J above and reimbursement requirements in SECTION 7. FEDERALLY QUALIFIED HEALTH CENTERS (FQHC), RURAL HEALTH CLINICS (RHC), AND INDIAN HEALTH CARE PROVIDERS (IHCP). In subcontracts with FQHCs, IHCPs and RHCs where a negotiated reimbursement rate is agreed to as total payment, a provision that such rate constitutes complete reimbursement and payment in full for the Covered Services rendered to the Member shall be included in the subcontract.

14. 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 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.

15. FINANCIAL VIABILITY OF SUBCONTRACTORS AND NETWORK PROVIDERS

Contractor must maintain a system to evaluate and monitor the financial viability of all Network Providers and Subcontractors that accept financial risk for the provision of Covered Services including, but not limited to, Dental Managed Care plans, independent Dentist/Provider associations, medical groups, hospitals, risk-bearing organizations as defined by 28 CCR section 1300.75.4(b), FQHCs, and other clinics.

16. PROVIDER SCREENING AND ENROLLMENT

All Network Providers must be screened and enrolled in accordance with Title 42 CFR 438.602(b), and APL 18-004.

1. DHCS, and other designated State departments, are required to enroll Network Providers in accordance with 42 CFR Section 438.602(b), APL 18-004. DHCS has provided Contractor with the option to enroll Network Providers under delegated authority in accordance with APL 18-004.

2. If Contractor elects to enroll Network Providers under its delegated authority, Contractor must screen and enroll Provider types for which there is an existing Medi-Cal Fee-For-Service state- level pathway. Contractor must also screen and enroll Provider types that are not currently enrolled in Medi-Cal FFS if those Provider types are necessary to maintain an adequate Network. Contractor shall confirm that a Provider is enrolled, or not subject to enrollment, prior to contracting with the Provider.

   If Contractor elects to enroll Network Providers, Contractor shall implement and maintain requirements for the screening and enrollment of Network Providers consistent with 42 CFR Section 438.602(b), and APL 19-004.

EXHIBIT A9: PROVIDER RELATIONS

1. EXCLUSIVITY

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

2. PROVIDER APPEALS

Contractor shall have a formal process to accept, acknowledge, and resolve provider appeals. A provider of dental services may submit to Contractor an 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 appeal within thirty (30) calendar days or document reasonable efforts to resolve the 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.

3. NON-CONTRACTING, NON-EMERGENCY PROVIDER COMMUNICATION

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

4. 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 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 SECTION 2. AUTHORIZATIONS AND REVIEW PROCEDURES.

5. NETWORK PROVIDER TRAINING

1. 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 A14: MEMBER SERVICES AND BENEFICIARY SUPPORT, 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 Network 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.

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

3. For Out-of-Network Providers who will not receive Network Provider training, Contractor shall develop and implement a process to provide them with Contractor's clinical protocols and evidence-based practice guidelines. Contractor shall arrange to provide these protocols and guidelines at the time that Contractor enters into an agreement with an Out-of-Network Provider.

4. In compliance with 42 CFR section 438.236(b), Contractor shall ensure that practice guidelines are based on valid and reliable clinical evidence or a consensus of Providers in that particular field, consider the needs of Contractor's Members, are adopted in consultation with Network Providers, and are reviewed and updated periodically as appropriate. In addition to Network Provider training, Contractor shall disseminate their practice guidelines to all affected Providers and upon request to Members.

6. PROHIBITED PUNITIVE ACTION AGAINST THE NETWORK 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 A10: PROVIDER COMPENSATION ARRANGEMENTS

1. COMPENSATION

Except as otherwise specified in this Attachment, Contractor may compensate Providers as Contractor and Provider negotiate and agree. Unless DHCS objects, compensation may be determined by a percentage of Contractor's payment from DHCS. This provision will not be construed to prohibit Contractor from entering into agreements in which compensation or other consideration is determined to be on a capitation basis.

All provider compensation arrangements, including but not limited to, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), Indian Health Care Providers (IHCPs) and specialists 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.

2. CAPITATION ARRANGEMENTS

Payments by Contractor to a Network Provider 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 Network Provider has been confirmed by Contractor. Capitation payments by Contractor to a Network Provider for a Member whose assignment to or selection Network Provider was not confirmed by Contractor on the date of the Member's enrollment, but is later confirmed by Contractor, shall be payable no later than thirty (30) calendar days after the Member's enrollment.

3. PROVIDER INCENTIVE PLAN

Contractor may compensate Providers through financial incentive program payments. Contractor must make available to Members, upon request, any provider incentive plans in place.

No specific payment may 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 must obtain DHCS pre-approval to implement the incentive program. Contractor must report all financial incentive programs related to this Contract in the form, manner, and frequency specified by DHCS.

4. IDENTIFICATION OF RESPONSIBLE PAYOR

Contractor shall provide information to the DHCS fiscal intermediary (FI) that identifies the payor responsible for reimbursement of services provided to a Member. Contractor shall identify the Network Provider or Subcontractor responsible for payment, if applicable, and the name and telephone number of the Provider responsible for providing care. Contractor shall provide this information upon DHCS' request and in a manner prescribed by DHCS.

5. CLAIMS PROCESSING

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

1. Contractor shall comply with Section 1932(f), Title XIX, Social Security Act (42 U.S.C. Section 1396u-2(f), and Health and Safety Code Sections 1371 through 1371.36. Contractor shall be subject to any remedies, including interest payments provided for in these sections, if it fails to meet the standards specified in these sections.

2. Contractor shall pay ninety percent (90%) of all clean claims from practitioners who are in individual or group practices or who practice in shared health facilities, including American Indian Health Service Program Providers, within thirty (30) days of the date of receipt and ninety-nine (99%) of all clean claims within ninety (90) days. The date of receipt shall be the date Contractor receives the claim, as indicated by its date stamp on the claim. The date of payment shall be the date of the check or other form of payment.

3. 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.

4. 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.

6. PROHIBITED CLAIMS AND PAYMENTS

1. 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, in accordance with 22 CFR 51002(a) and Welfare & Institutions Code Section 14019.4(a). Collection of a claim may be made under those circumstances described in 22 CCR 53220 and 53222.

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

3. In accordance with 42 USC section 1396b(i)(2), Contractor must not pay any amount for any services or items, other than Emergency Services, to an Excluded Provider pursuant to EXHIBIT

A8: PROVIDER NETWORK of this Contract. This prohibition shall apply to non-emergent services furnished by a Provider at the medical direction or prescribed by an Excluded Provider when the Provider knew or had a reason to know of the exclusion, or by an Excluded Provider to whom DHCS has failed to suspend payment while pending an investigation of a credible allegation of fraud.

7. FEDERALLY QUALIFIED HEALTH CENTERS (FQHC), RURAL HEALTH CLINICS (RHC), AND INDIAN HEALTH CARE PROVIDERS (IHCP)

7.1. REIMBURSEMENT OF NON-CONTRACTING FQHCS, RHCS, IHCPS

a. If FQHC, RHC and IHCP 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 IHCPs for services provided to Contractor's Members at a level and amount of payment that is not less than Contractor makes for the same scope of services furnished by a provider that is not a FQHC, RHC or IHCP.

b. Emergency services rendered by a non-contracting FQHC, RHC or IHCP shall be reimbursed as specified in SECTION 7. FEDERALLY QUALIFIED HEALTH CENTERS (FQHC), RURAL HEALTH CLINICS (RHC), AND INDIAN HEALTH CARE PROVIDERS (IHCP) of this Attachment.

c. If FQHC, RHC or 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 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 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 IHCP shall be reimbursed as specified in SECTION 7. FEDERALLY QUALIFIED HEALTH CENTERS (FQHC), RURAL HEALTH CLINICS (RHC), AND INDIAN HEALTH CARE PROVIDERS (IHCP).

d. 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.

7.2. FEDERALLY QUALIFIED HEALTH CENTERS/RURAL HEALTH CLINICS /INDIAN HEALTH CARE PROVIDERS (FQHC/RHC/IHCP)

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 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 reimbursement to ensure compliance with State and federal law and shall approve all FQHC, RHC and IHCP subcontracts consistent with the provisions of Welfare and Institutions Code Section 14087.325(h).

To the extent that IHCPs qualify as FQHCs or RHCs, the above reimbursement requirements shall apply to subcontracts with IHCPs.

7.3. INDIAN HEALTH CARE PROVIDERS (IHCP)

Contractor shall reimburse IHCPs for dental care services provided to Members who are qualified to receive services from an IHCP according to one of the reimbursement options in 22 CCR 55140(a). Contractor shall make payment to IHCPs in a timely manner as required for payments to practitioners in individual or group practices under 42 CFR Section 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 ninety percent (90%) of all clean claims from Providers (i.e. those who are in individual or group practice or who practice in shared health facilities) within thirty (30) days of the date of receipt; and paying ninety-nine (99%) of all clean claims from practitioners (who are in individual or group practice or who practice in shared health facilities) within ninety (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 Contractor, an amount equal to the amount 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 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 Contractor, it has the right to receive its applicable All Inclusive Rate published annually in the

Federal Register by the federal IHS, or in the absence of a published All Inclusive 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 Contractor and IHCP or, in the absence of a negotiated rate, at a rate not less than the level and amount of payment 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

8. NON-CONTRACTING EMERGENCY SERVICE PROVIDERS

1. Contractor is responsible for coverage and payment of Emergency Services, and must cover and pay for Emergency Services regardless of whether the Provider that furnishes the services has a contract with Contractor. Contractor may not deny payment for treatment obtained when a Member had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 CFR section 438.114(a) of the definition of Emergency Medical Condition. Further, Contractor may not deny payment for treatment obtained when a representative of Contractor instructs the Member to seek Emergency Services.

2. Contractor must allow payment for services rendered during an emergency without requiring its contracting providers to submit required documentation if the contracting provider is in good standing under the Medi-Cal program and is not able to submit claims due to destruction, loss, or inaccessibility of data as a result of the emergency. When processing payments for emergency services, Contractor must request that contracting providers provide an adequate justification for payment and limit emergency payment requests to six (6) months from the date of the emergency declaration. Contractor must base its emergency payment on the contracting provider's previous claims history.

3. Contractor must reimburse providers 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 Contractor. Emergency services shall not be subject to prior authorization by Contractor.

4. 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.

5. 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 Managed Care Plans, pursuant to this Provision shall be made in accordance with Provision E Claims Processing, above, and 42 USC 1396u-2(b)(2)(D).

6. 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.

7. Contractor may not deny payment for treatment when a representative of 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.

8. 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 section 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.

9. COMPLIANCE WITH DIRECTED PAYMENT INITIATIVES AND RELATED REIMBURSEMENT REQUIREMENTS

1. Contractor shall reimburse, or require its Subcontractors to reimburse, Providers in accordance

with the terms and conditions of each applicable Directed Payment Initiative under 42 CFR section 438.6(c) in a form and manner specified by DHCS through APLs or other technical guidance. For applicable Rating Periods, DHCS shall make the terms of each Directed Payment Initiative available on the DHCS website.

2. Contractor shall reimburse, or require its Subcontractors to reimburse, Providers in accordance with the terms and conditions of each applicable alternative payment model established by DHCS, in accordance with the CMS approved rate certification, and in a form and manner specified by DHCS through APLs or other technical guidance.

EXHIBIT A11: ACCESS AND AVAILABILITY

1. GENERAL REQUIREMENT

1. 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.

2. 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 Title 22 CCR Section 53853(a) and consistent with all specified requirements.

3. If Contractor has an approved Alternate Access Standard (AAS) for an applicable Specialist Contractor; they are required to assist any requesting Member in obtaining an appointment with an appropriate Out-Of-Network core Specialist, in person or via teledentistry, if clinically appropriate. When assisting the Member, Contractor must make its best effort to establish a Member-specific case agreement with an Out-Of-Network core Specialist at the Medi-Cal Fee-For-Service rate or a mutually agreed upon rate, unless Contractor has already attempted to establish a Member-specific case agreement with the Out-Of-Network Specialist in the most recent fiscal year, and the Specialist has refused to enter into an agreement.

    a. If this cannot be arranged, Contractor must arrange for an appointment with a Network Specialist.

    b. The Out-Of-Network Specialist must be able to provide services to a Member within the applicable time or distance and timely access standards and, in cases where the Out-Of-Network Specialist is not able to provide services to a Member under these standards, Contractor must arrange for Non-Emergency Medical Transportation or Non-Medical Transportation.

2. ACCESS REQUIREMENTS

Contractor shall establish acceptable accessibility standards in accordance with 28 CCR 1300.67.2, 1300.67.1, Welfare and Institutions Code 14197 (a)(3), and Dental APL 18-003 and as specified below. Contractor shall ensure that contracting providers offer hours of operation that are no less than the hours of operation offered to commercial Members or comparable to Medi-Cal Dental Fee-for-Service (FFS), if

the provider serves only Medi-Cal Dental FFS Members. DHCS will review and approve standards for reasonableness. Contractor shall communicate, enforce, and monitor providers' compliance with these standards.

2.1. 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.

2.2. 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 SECTION 2.1. APPOINTMENTS, above. 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.

2.3. 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.

2.4. AFTER HOUR CALLS

At a minimum, Contractor shall ensure that a dentist or an appropriate licensed professional under his/her supervision will be available, twenty four (24) hours a day, seven (7) days a week, for after-hours calls.

2.5. 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 A19: DELIVERABLE TEMPLATES) on a biannual basis, no later than January 31st and July 31st of each fiscal 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.

2.6. 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 twenty-four (24) hours a day, seven (7) days a week.

Contractor shall cover emergency dental services without prior authorization pursuant to 22 CCR 53216 and 28 CCR 1300.67(g) and in accordance with Welfare & Institutions Code Section 14454 and APL 16-016.

2.7. STANDING REFERRALS

Contractor shall have in place a procedure for a Member to receive a standing referral to a Specialist if the primary care dentist determines, in consultation with the Specialist and Contractor's Dental Director or the Dental Director's designee, that a Member needs continuing care from a Specialist. If a treatment plan is necessary in the course of care and is approved by Contractor, in consultation with the Primary Care Dentist, Specialist, and Member, a referral shall be made in accordance with the treatment plan.

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

3. ACCESS STANDARDS

Contractor shall ensure timely access to services in accordance with W&I Code Section 14197, Title 28 CCR Section 1300.67.2.2 and as specified below. Contractor shall communicate, enforce, and monitor Network Providers' compliance with timely access standards.

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 A19: DELIVERABLE TEMPLATES) on a quarterly basis, no later than thirty (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.

3.1. APPROPRIATE CLINICAL TIMEFRAMES

Contractor shall ensure that Members are offered appointments for covered dental services within a time

period appropriate for their condition.

3.2. STANDARDS FOR TIMELY APPOINTMENTS

Members must be offered appointments within the following timeframes:

a. Initial Appointment – within four (4) weeks

b. Routine Appointment (non-emergency) – within four (4) weeks

c. Preventive Dental Care Appointment – within four (4) weeks

d. Specialist Appointment – within thirty (30) business days from authorized request for adult Members, and within thirty (30) calendar days from request for child Members

e. Emergency Appointment – within twenty-four (24) hours from the request for appointment

3.3. SHORTENING OR EXPANDING TIMEFRAMES

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

3.4. PROVIDER SHORTAGE

Contractor shall arrange for a Member to receive timely care as necessary for their health condition if timely appointments within the time or distance standards required in SECTION 6. TIME AND DISTANCE STANDARD of this Contract are not available. Contractor shall refer Members to, or assist Members in locating, available and accessible Network Providers in neighboring service areas or Out-of-Network Providers for obtaining health care services in a timely manner appropriate for the Member's needs.

3.5. CALL CENTER WAIT TIME STANDARDS

Contractor shall ensure that, during normal business hours, the waiting time for a Member to speak by telephone with a Contractor's customer service representative who is knowledgeable and competent regarding the Member's questions and concerns shall not exceed ten (10) minutes as required by Title 28 CCR Section 1300.67.2.2(c)(10).

4. CHANGES IN AVAILABILITY OR LOCATION OF COVERED SERVICES

1. Contractor must provide notification to DHCS immediately upon discovery of a Provider initiated termination, or at least sixty (60) calendar days before making any Significant Change in the availability or location of services to be provided under this Contract, and APL 18-003E, if it affects more than two thousand (2,000) Members or affects Contractor's ability to meet Network adequacy standards. In the event of an emergency or other unforeseeable circumstances, Contractor must notify DHCS of the change in availability or location of services as soon as possible.

2. Contractor must provide notification to DHCS immediately or within ten (10) calendar days of learning of a Provider's exclusionary status from any database or list included in APL18-004.

5. ACCESS FOR MEMBER WITH DISABILITIES AND LANGUAGE AND COMMUNICATION ASSISTANCE

1. Contractor shall comply with the requirements of titles II and III of the Americans with Disabilities Act of 1990, section 1557 of the Affordable Care Act of 2010, sections 504 and 508 of the Rehabilitation Act of 1973, Government Code sections 11135 and 7405, and all applicable implementing regulations, and shall ensure access for people with disabilities which includes, but is not limited to, accessible web content, ramps, elevators, restrooms, designated parking spaces, and drinking water provisions.

2. Contractor shall ensure compliance with all State and federal language and communication assistance requirements, including, without limitation, section 1557 of the Affordable Care Act of 2010 (42 U.S. Code § 18116, 45 CFR Part 92) title VI of the Civil Rights Act of 1964 (42 USC Section 2000d, 45 C.F.R. Part 80), section 438.10 of title 42 of the Code of Federal Regulations, Government Code section 11135, and W&I Code section 14029.91.

3. Contractor shall ensure equal access to oral health care services for Limited English Proficient (LEP) Members or Potential Enrollees and Members or Potential Enrollees with disabilities, through provision of high-quality interpreter and linguistic services in compliance with federal and State law, and APL 21-001.

6. POPULATION HEALTH MANAGEMENT (PHM) PROGRAM REQUIREMENTS

Contractor must develop and maintain a Population Health Management (PHM) program that ensures all Members have appropriate access to necessary wellness and prevention services, Care Coordination and care management. Contractor must assess each Member's needs across the continuum of care based on Member preferences, data-driven risk stratification, identified gaps in care and standardized assessment

processes. Contractor must maintain a PHM program that seeks to improve the health outcomes of all Members consistent with the requirements set forth in this Section and DHCS guidance.

Contractor must ensure its PHM program meets PHM standards as well as applicable federal and state requirements. Contractor must conduct a Population Needs Assessment (PNA) as described in SECTION 7.3. POPULATION NEEDS ASSESSMENT (PNA) and submit a Population Health Management Strategy (PHMS) to DHCS for approval that details all components of its PHM program activities in accordance with the requirements of this Section and the DHCS Comprehensive Quality Strategy. Contractor must engage Safety Net Providers, community-based organizations, Regional Centers (RCs), Local Dental Societies, Local Oral Health Programs with the service area, Child Welfare Agencies and other stakeholders identified in SECTION 7.3. POPULATION NEEDS ASSESSMENT (PNA) to develop its PNA and PHMS and when developing new Initiatives.

6.1. DATA INTEGRATION EXCHANGE

In accordance with the CMS Interoperability and Patient Access final rule (CMS-9115-F) and applicable federal and state data exchange requirements, Contractor must integrate its PHM data by expanding its Management Information System (MIS) capabilities, as follows:

a. Integrate additional data sources to ensure the ability to assess the needs and characteristics of all Members;

b. Enhance interoperability of its MIS to allow for data exchange with Health Information Technology (HIT) systems and Health Information Exchange (HIE) networks as specified by the DHCS;

c. Enhance interoperability in support of population health principles, integrated care, and Care Coordination across delivery systems;

d. Provide DHCS with administrative, clinical, and other data requirements as specified by the DHCS; and

e. Comply with all data sharing agreements, including data exchange policies and procedures, as defined by the California Health and Human Services Data Exchange Framework in accordance with Health & Safety (H&S) Code section 130290.

7. CULTURAL AND LINGUISTIC PROGRAM

Contractor shall have a Cultural and Linguistic Services Program that incorporates the requirements of Title 22 CCR Section 53876. Contractor shall monitor, evaluate, and take effective action to address any needed improvement in the delivery of culturally and linguistically appropriate services. Contractor shall review and update their cultural and linguistic services consistent with the Population Needs Assessment

(PNA) requirements stipulated below.

7.1. WRITTEN DESCRIPTION

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

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

b. Goals and objectives.

c. A timetable for implementation and accomplishment of the goals and objectives.

d. An organizational chart showing the key staff persons with overall responsibility for cultural and linguistic services and activities. A narrative shall explain the chart and describe the oversight and direction to the Community Advisory Committee, provisions for support staff, and reporting relationships

e. Qualifications of staff, including appropriate education, experience and training shall also be described.

f. Standards and Performance requirements for the delivery of culturally and linguistically appropriate health care services.
scheduling.

7.2. LINGUISTIC CAPABILITY OF EMPLOYEES

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

7.3. POPULATION NEEDS ASSESSMENT (PNA)

Contractor must conduct a PNA at least annually and must use results from the PNA to develop its PHMS. Contractor must use the PNA to identify population-level health and social needs, including Health Disparities, and to provide and maintain culturally competent and linguistically appropriate services and translations. Contractor must implement Oral Health Access, health education, and continuous Quality Improvement (QI) programs and services, and determine relevant subpopulations for targeted, person-centered interventions. Contractor must develop the PNA in accordance with the following requirements:

a. Contractor’s PNA must evaluate, at a minimum, the following factors for its entire Member

population, including, but not limited to:

1. General characteristics and oral health needs;
2. Health status, behaviors and utilization trends, including use of Emergency Services;
3. Oral Health education, and cultural and linguistic needs;
4. Oral Health Disparities;
5. Social Drivers of Health (SDOH); and
6. Any gaps in services and resources even if they are not Covered Services under this contract.

b. Contractor's PNA must consider all relevant data for its entire Member population, including, but not limited to:

   a. Data from Subcontractors; and

   b. Needs assessments conducted by other entities and community-based organizations within Contractor's Service Area.

c. Contractor must use reliable data sources, including Subcontractor and Downstream Subcontractor level data, to conduct and update the PNA at least annually. Reliable data sources must include the most recent results from the Member satisfaction survey and DHCS Health Disparities data.

d. In order to assess Member needs in Contractor's Service Area, Contractor must engage representatives of Safety Net Providers, community based organizations, Regional Centers (RCs), Local Dental Societies, Local Oral Health Programs with the service area, Child Welfare Agencies as well as stakeholders from special needs groups, including Seniors and Persons with Disabilities (SPD), Children with Special Health Care Needs (CSHCN), Members with Limited English Proficiency (LEP), and other Member subgroups from diverse cultural and ethnic backgrounds.

e. Contractor must provide a report on the PNA to its Community Advisory Committee (CAC). Contractor must have a process to obtain input, advice, and recommendations on the PNA from its CAC.

f. Based on the PNA, Contractor must annually review and update the following in accordance with the population-level needs and the DHCS Comprehensive Quality Strategy

1. Targeted health education materials for Members;

2. Member-facing outreach materials for any identified gaps in services and Resources;

3. Cultural and linguistic, and QI strategies to address identified population-level health and social needs; and

4. Wellness and prevention programs.

g. Contractor must produce its PNA in writing, make it available to the public, and post it on its website.

7.4. DIVERSITY, EQUITY AND INCLUSION TRAINING

Contractor must provide annual sensitivity, diversity, cultural competency and Oral Health Access training for its employees and contracted staff. Training must consider structural and institutional racism and Health Disparities and their impact on Members, staff, Network Providers, Subcontractors. Contractor must ensure Network Providers and their Personnel receive pertinent information regarding the PNA findings and the identified targeted strategies. Contractor must use the most appropriate communication method(s) to assure the information can be accessed and understood. The training must include the following requirements:

1. Promote access and delivery of services in a culturally competent manner to all Members and Potential Members, regardless of race, ethnicity, language, age, geographic location, disability, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code 422.56; and

2. Information about the Oral Health Disparities and identified cultural groups in Contractor's Service Area which includes but is not limited to: the groups' beliefs about illness and oral health; methods of interacting with Providers and the health care structure; traditional home remedies that may impact what the Provider recommends to treat the patient; and language and literacy needs.

7.5. LINGUISTIC SERVICES

a. Contractor shall ensure equal access to dental care services for limited English proficient Members through provision of high-quality interpreter and linguistic services in accordance with APL 21-001.

b. 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 Members receive 24-hour interpreter services at all key points of contact, as defined in Sub provision 3 of this Provision, either through interpreters or telephone language services.

c. In accordance with 42 CFR 438.10(d), Contractor shall provide, at minimum, the following linguistic services at no cost to Medi-Cal Members:

    1. 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.

    2. Fully translated written informing materials, including but not limited to the Provider Directories, Member services guide, Member 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 Contractor's service area, and by 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.

    3. Referrals to culturally and linguistically appropriate Covered Services 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, Scope of Services, that are delivered in a manner that meets their unique needs, including, but not limited to, sexual orientation or gender identity.

    4. 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 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.

5. Contractor must notify its Members:

    a. That oral interpretation is available for any language and written translation is available in threshold languages;

    b. That auxiliary aids and services are available upon request and at no cost for Members with disabilities; and

    c. How to access the services in paragraphs (K)(e)(1) and (2) of this section.

6. Contractor must provide all written materials for potential Members and Members consistent with the following:

    a. Use easily understood language and format.

    b. Use a font size no smaller than 12 point.

    c. 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.

    d. 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 20 point.

7. 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.

8. 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.

7.6.

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 three thousand (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 one thousand (1,000) in a single ZIP code or one thousand five hundred (1,500) in two contiguous ZIP codes.

   1. 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.

8. COMMUNITY ADVISORY COMMITTEE

Contractor shall form a Community Advisory Committee (CAC) and meet periodically with the committee concerning the development and implementation of its cultural and linguistic accessibility standards and procedures.

1. Contractor must convene a CAC selection committee tasked with selecting the members of the CAC. Contractor must demonstrate a good faith effort to ensure that the CAC selection committee is comprised of a representative sample of each of the persons below to bring different perspectives, ideas, and views to the CAC

2. The CAC Selection Committee must ensure the CAC membership attempts to reflect the general

Medi-Cal Member population in Contractor's Service Area, including representatives from adolescents and/or parents and/or caregivers of children, including foster youth, as appropriate and be modified as the population changes to ensure that Contractor's community is represented and engaged. The CAC selection committee must make good faith efforts to include representatives from diverse and hard-to-reach populations on the CAC, with a specific emphasis on persons who are representative of or serving populations that experience Health Disparities such as individuals with diverse racial and ethnic backgrounds, genders, gender identity, and sexual orientation and physical disabilities.

3. Contractor's CAC selection committee must select all of its CAC members promptly no later than 180 calendar days from the effective date of this contract.

4. Should a CAC member resign, is asked to resign, or is otherwise unable to serve on the CAC, Contractor must make its best effort to promptly replace the vacant seat within 60 calendar days of the CAC vacancy.

5. Contractor must designate a CAC coordinator and maintain a written job description detailing the CAC coordinator's responsibilities, which must include having responsibility for managing the operations of the CAC in compliance with all statutory, rule, and contract requirements, including, but not limited to:

    a. Ensuring committee meetings are scheduled and committee agendas are developed with the input of CAC members;

    b. Maintaining committee membership, including outreach, recruitment, and onboarding of new members, that is adequate to carry out the duties of the CAC;

    c. Actively facilitating communications and connections between the CAC and Contractor leadership, including ensuring CAC members are informed of Contractor decisions relevant to the work of the CAC;

    d. Ensuring that CAC meetings, including necessary facilities, materials, and other components, are accessible to all participants and that appropriate accommodations are provided to allow all attending the meeting, including, but not limited to, accessibility for individuals with a disability or LEP Members to effectively communicate and participate in CAC meetings;

    e. Ensuring compliance with all CAC reporting and public posting requirements; and

    f. The CAC coordinator may be an employee of Contractor or Subcontractor. Contractor's

CAC coordinator must not be a member of the CAC or a member enrolled with Contractor.

6. CAC Meetings

   a. Contractor must hold its first regular CAC meeting promptly after all initial CAC members have been selected by the CAC selection committee and quarterly thereafter.

   b. Contractor must make the regularly scheduled CAC meetings open to the public, posting meeting information publicly on Contractor's website in a centralized location 30 calendar days prior to the meeting, and in no event later than 72 hours prior to the meeting.

   c. Contractor must provide a location for CAC meetings and all necessary tools and materials to run meetings, including, but not limited to, making the meeting accessible to all participants and providing accommodations to allow all individuals to attend and participate in the meetings.

   d. CAC must draft written minutes of each of its meetings and the associated discussions. All minutes must be posted on Contractor's website and submitted to DHCS no later than 45 calendar days after each meeting. Contractor must retain the minutes for no less than 10 years and provided to DHCS, upon request.

   e. Contractor must demonstrate that CAC input is considered in annual reviews and updates to relevant policies and procedures, including CAC input that is relevant to policies and procedures affecting quality and Oral Health Access. Contractor must provide a feedback loop to inform CAC members how their input has been incorporated

7. Duties of the CAC

   The CAC shall carry out the duties as set forth in this Contract. Such duties include, but are not limited to:

   a. Identifying and advocating for preventive care practices to be utilized by the Contractor;

   b. Contractor must ensure that the CAC is included and involved in developing and updating cultural and linguistic policy and procedure decisions including those related to QI, education, and operational and cultural competency issues affecting groups who speak a primary language other than English. The CAC may also advise on necessary Member or Provider targeted services, programs, and trainings;

c. The CAC must provide and make recommendations to Contractor regarding the cultural appropriateness of communications, partnerships, and services;

d. The CAC must review PNA findings and have a process to discuss improvement opportunities with an emphasis on Oral Health Access and Social Drivers of Health (SDOH). Contractor must allow its CAC to provide input on selecting targeted health education, cultural and linguistic, and QI strategies;

e. Contractor must provide sufficient resources for the CAC to support the required CAC activities outlined above, including supporting the CAC in engagement strategies such as consumer listening sessions, focus groups, and/or surveys; and

f. The CAC must provide input and advice, including, but not limited to, the following:

    1. Culturally appropriate service or program design;

    2. Priorities for oral health education and outreach program;

    3. Member satisfaction survey results;

    4. Findings of the PNA;

    5. Plan marketing materials and campaigns.

    6. Communication of needs for Network development and assessment;

    7. Community resources and information;

    8. Population Health Management;

    9. Quality;

    10. Health Delivery Systems Reforms to improve health outcomes;

    11. Coordination of Care;

    12. Oral Health Access; and

    13. Accessibility of Services

8. Contractor's Annual CAC Demographic Report

    a. To ensure Contractor's CAC membership is representative of the Communities in Contractor's Service Area, Contractor must complete and submit to DHCS annually an Annual CAC Member Demographic Report by April 1 of each year. The Annual CAC Member Demographic Report must included descriptions of all of the following:

        1. The demographic composition of CAC membership;

        2. How Contractor defines the demographics and diversity of its Members and Potential Members within Contractor's Service Area;

        3. The data sources relied upon by Contractor to validate that its CAC membership aligns with Contractor's Member demographics;

        4. Barriers to and challenges in meeting or increasing alignment between CAC's membership with the demographics of the Members within Contractor's Service Area;

        5. Ongoing, updated and new efforts and strategies undertaken in CAC membership recruitment to address the barriers and challenges to achieving alignment between CAC membership with the demographics of the Members within Contractor's Service Area; and

        6. A description of the CAC's ongoing role and impact in decision-making about Oral Health Access, health-related initiatives, cultural and linguistic services, resource allocation, and other community-based initiatives, including examples of how CAC input impacted and shaped Contractor initiatives and/or policies.

9. COMMUNITY ENGAGEMENT

Contractor must develop a policy and procedure for a Member and family engagement strategy that involves Members and families as partners in the delivery of Covered Services. This includes, but is not limited to the following:

1. Maintaining an organizational leadership commitment to engaging with members and their families in the delivery of care;

2. Routinely engaging with Members and families through focus groups, listening sessions, surveys

and/or interviews and incorporating results into policies and decision-making, as described in SECTION 9. QUALITY IMPROVEMENT AND ORAL HEALTH ACCESS ANNUAL PLAN;

3. Developing processes and accountability for incorporating Member and family input into policies and decision-making;

4. Developing processes to measures and/or monitor the impact of Member and family input into policies and decision-making;

5. Developing processes to share with Members and families how their input impacts policies and decision-making;

6. Conducting consumer surveys and incorporating results in Quality Improvement (QI) and Oral Health Access activities as described in SECTION 10.3. CONSUMER SATISFACTION SURVEY;

7. Partnering with community based organizations to cultivate Member and family engagement;

8. Maintaining a CAC whose composition reflects the Contractor's Member population and whose input is actively utilized in policies and decision-making by the Contractor, as outlined below in ATTACHMENT 11: CONFLICT OF INTEREST COMPLIANCE CERTIFICATE, Provision H.

10. OUT-OF NETWORK PROVIDER

1. If Contractor's Network is unable to provide necessary services covered under the Contract to a particular Member, Contractor must adequately and timely cover these services out-of-Network for the Member, for as long as the entity is unable to provide them. Out-of-Network Providers must coordinate with the entity with respect to payment. Contractor must ensure that cost to the Member is not greater than it would be if the services were furnished within the Network.

2. Contractor shall provide for the completion of covered services by a terminated or Out-of-Network Provider at the request of a Member in accordance with the continuity of care requirements in Health and Safety Code Section 1373.96.

3. For newly enrolled Members who request continued access, Contractor shall provide continued access for up to 12 months to an Out-of-Network Provider with whom they have an ongoing relationship if there are no quality of care issues with the Provider and the Provider will accept Contractor or Medi-Cal FFS rates, whichever is higher, in accordance with APL 17-011E.

11. 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, 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 A12: SCOPE OF SERVICES

1. COVERED SERVICES

Contractor shall provide or arrange for Members all medically necessary dental covered services and other dental 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, and 51003, and the Medi-Cal Dental Manual of Criteria, unless otherwise specifically excluded under the terms of this Contract. 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 Dental FFS.

Contractor shall ensure that services provided are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the Covered Services are furnished, and may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. Contractor may place appropriate limits on a service on the basis of criteria such as Medical Necessity; or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose and the services supporting Members with ongoing or chronic conditions, provided in a manner that reflects the Member's ongoing needs.

2. MEDICALLY NECESSARY COVERED DENTAL SERVICES

For purposes of this Contract, the term "medically necessary covered dental 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 ability for a Member to achieve age-appropriate growth and development, and to attain, maintain, or regain functional capacity. "Medically necessary dental 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.

3. SERVICES FOR MEMBERS UNDER 21 YEARS OF AGE

In addition to SECTION 2. MEDICALLY NECESSARY COVERED DENTAL SERVICES, Contractor shall ensure the provision of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services for Members under twenty-one (21) years of age in accordance with Dental APL 19-001 and 22 CCR 51340 and 51340.1. 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.

4. For Members under twenty-one (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 at a minimum shall be required to:

1. Include relevant language on EPSDT services from the Medi-Cal Dental provider Handbook in the plan's provider manuals;

2. Provide specific training on EPSDT services to plan's provider network; In the training provider must include a reference to the Medi-Cal Kids & Teens Outreach & Education Toolkit

3. Describe the process to review EPSDT requests, including how the provider and Member will be notified of their disposition.

4. SERVICES FOR ALL MEMBERS

1. Health Education – All Medi-Cal Dental Managed Care Plans

    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 must include training or a reference directing members to the Medi-Cal Kids & Teens Outreach & Education Toolkit. 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 Contractor’s health education programs and services and all materials related to health education for review and approval.

EXHIBIT A13: CASE MANAGEMENT AND COORDINATION OF CARE

1. 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 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 Contractor furnishes to the Member:

    a. Between settings of care;

    b. Following the use of any emergency room services involving oral health. Contractor shall contact the beneficiary within five (5) business days of receipt of information (by data transmittal from DHCS) that the Member has received emergency room services. Contractor shall be required to receive the data transmittals at least on a monthly basis;

    c. With the services the Member receives from any other Medi-Cal managed care plan, including both medical and dental managed care;

    d. With the services the Member receives in Medi-Cal Fee-for-Service delivery systems; and

    e. 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, from one DMC to another, or from Covered California to Medi-Cal 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), 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 described in SECTION 3. OUT-OF-PLAN CASE MANAGEMENT AND COORDINATION OF CARE.

2. DISEASE MANAGEMENT PROGRAM

Contractor is responsible for initiating and maintaining a disease management program. Contractor shall determine the program's targeted disease conditions and implement a system to identify and encourage Members to participate.

Contractor must submit and receive DHCS approval, Contractor's policies and procedures for administration of a disease management program, including procedures for identification and referral of Members eligible to participate in the disease management program.

3. 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 SECTION 4. INITIAL ORAL HEALTH ASSESSMENT REQUIREMENT and SECTION 5. SERVICES FOR MEMBERS WITH SPECIAL HEALTH CARE NEEDS below.

4. INITIAL ORAL HEALTH ASSESSMENT REQUIREMENT

Contractor shall develop and implement an initial health screening and oral health assessment 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 Dental APLs issued by DHCS. Consistent with the federal requirement, 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.

1. Contractor shall make a best effort to conduct an initial screening of each Member's needs, within ninety (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. Contractor must make at least three attempts to contact a Member to conduct the initial screening or assessment using different available modalities.

2. 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.

3. Contractor shall generate an Initial Oral Health Assessment report and submit it to the Department on a monthly basis. The report shall demonstrate and summarize compliance with outcomes in this area and submit the compliance report quarterly.

5. 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 Section 438.208(c) and any related Dental 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, Contractor shall produce a treatment or service plan that meets the following criteria:

    a. Approved by Contractor in a timely manner, if approval is required by 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 twelve (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.

6. 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. 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. Methods for ensuring and monitoring timely access to pediatric specialists, specialists, 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. Methods for ensuring that each CSHCN receives a comprehensive oral assessment and development of a written dental treatment plan.

4. Case management or care coordination for CSHCN, including coordination with the child's medical managed care plan for surgical center 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. Methods for monitoring and improving the quality and appropriateness of care for CSHCN.

7. 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 (5) days of discovering the condition and confirming that the patient is a Medi-Cal beneficiary.

6. The Contract prohibits 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

8. SERVICES THAT MAY BE COVERED BY CONTRACTOR

A Contractor may cover, for Members, services or settings that are in lieu of services or settings covered under the State plan as follows:

1. 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.

2. The Member is not required by Contractor to use the alternative service or setting.

3. The approved in lieu of services are authorized and identified in Contractor’s Contract, and will be offered to enrollees at the option of Contractor.

EXHIBIT A14: MEMBER SERVICES AND BENEFICIARY SUPPORT

1. MEMBERS RIGHTS AND RESPONSIBILITIES

1.1. 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 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 file a grievance, either verbally or in writing, 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 Contractor to make an authorization decision. In addition, to have access to Contractor's grievance and appeal system, according to EXHIBIT A15: MEMBER GRIEVANCE AND APPEAL SYSTEM.

6. To receive oral interpretation services for their language;

7. To have access to Federally Qualified Health Centers, American Indian Health Service Programs, and emergency services outside of the Contractor's Network pursuant to federal law.

8. To request a State Medi-Cal fair hearing, including information on the circumstances under

which an expedited fair hearing is possible.

9. To have access to, and where legally appropriate, receive copies of, amend or correct their Medical Record.

10. To change Medi-Cal Dental Managed Care Health Plans upon request, if applicable.

11. To receive written Member informing materials in alternative formats, including Braille, large size print, and audio format upon request and in accordance with W & I Code Section 14182 (b)(12).

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

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

14. To receive a copy of the Member's Medical Records, and request that they be amended or corrected, as specified in 45 CFR sections 164.524 and 164.526.

15. Freedom to exercise these rights without adversely affecting how they are treated by Contractor, Network Providers, Subcontractors, or the State.

16. To file a request for an Appeal of an action within 60 days of the date on a NOA.

17. Be free of discrimination based on discrimination based on sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, or identification with any other persons or groups defined in Penal Code 422.56.

1.2. MEMBERS' RIGHT TO CONFIDENTIALITY

Contractor shall implement and maintain policies and procedures to ensure the Members' right to confidentiality of medical information.

a. Contractor shall ensure that Facilities implement and maintain procedures that guard against disclosure of confidential information to unauthorized persons inside and outside the Network.

b. Contractor shall counsel Members on their right to confidentiality and Contractor shall obtain

Member's consent prior to release of confidential information, unless such consent is not required pursuant to Title 22 CCR Section 51009.

1.3. INOPERABILITY REQUIREMENTS FOR MEMBER RECORDS

Contractor must implement and maintain a Patient Access Application Programming Interface (API) as specified in 42 CFR section 431.60 as if such requirements applied directly to Contractor, and as set forth in APL 22-026. The Patient Access API must also meet the technical standards in 45 CFR section 170.215. Data maintained on or after January 1, 2016, must be made available to facilitate the creation and maintenance of a Member's cumulative health record.

a. At a minimum, Contractor must permit third-party applications to retrieve, with the approval and at the direction of the Member, the following Member records:

    1. Adjudicated claims data from Contractor, and from any Subcontractors and Network Providers, including claims data and cost data that may be appealed, or are in the process of appeal, Provider remittances, and Member cost-sharing pertaining to such claims, within (1) Working Day after a claim is processed;

    2. Encounter Data, including Encounter Data from any capitated Subcontractors and Network Providers, within one (1) Working Day after receiving the data from Providers;

    3. Clinical data, including diagnoses and related codes, and laboratory test results, within one (1) Working Day after the data is received by the Contractor; and

    4. Information about coverage for drugs administered in an outpatient setting as part of medical services, and updates to such information, including, if applicable, Member costs and any preferred drug list information, within one (1) Working Day after the effective date of any such information or updates to such information.

Contractor may deny or discontinue any third-party application's connection to an API if it reasonably determines, consistent with its security risk analysis under the HIPAA Security Rule, that continued access presents an unacceptable level of risk to the security of protected health information on its systems. The determination must be made using objective verifiable criteria that are applied fairly and consistently across all applications and developers, including but not limited to criteria that may rely on automated monitoring and risk mitigation tools.

2. 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 twelve (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 (10) minutes, in accordance with 28 CCR 1300.67.2.2(c)(10).

3. 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 A19: 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 percent (7%). “P’ factor is defined as the percentage of connected calls versus non-connected calls and/or busy signals.

4. 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. To provide Member information in any format other than as printed materials, including but not limited to in electronic format or upon request, Contractor must submit their process to DHCS for review and approval before implementing.

    a. Distribution of Member Information shall be considered provided after Contractor completes one of the following:

        1. Mails a printed copy of the information to the enrollee's mailing address.

        2. Provides the information by email after obtaining the enrollee's agreement to receive the information by email.

        3. 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.

        4. 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 (6th) 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 SECTION 7. CULTURAL AND LINGUISTIC PROGRAM.

    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.

Contractor shall post a DHCS-approved nondiscrimination notice. Contractor shall also post a notice with language taglines in a conspicuously visible font size in English, at least the top 15 non-English languages in the State, and any other languages as determined by DHCS, explaining the availability of free language assistance services, including written translation and oral interpretation, and information on how to request Auxiliary Aids and services, including materials in alternative formats. The nondiscrimination notice and the notice with taglines shall include Contractor's toll-free and the TTY/TDD telephone number for obtaining these services, and shall be posted as follows:

a. In a conspicuous place in all physical locations where Contractor interacts with the public;

b. In a location on Contractor's website that is accessible on Contractor's home page, and in a manner that allows Members, Potential Enrollees, and members of the public to easily locate the information; and

c. Contractor's nondiscrimination notice shall include all information required by W&I Code Section 14029.91(e), any additional information required by DHCS, and shall provide information on how to file a discrimination Grievance with:

    1. Both Contractor and the DHCS Office of Civil Rights, if there is a concern of discrimination based on sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, or identification with any other persons or groups defined in Penal Code 422.56.

    2. The United States Department of Health and Human Services Office for Civil Rights if there is a concern of discrimination based on race, color, national origin, sex, age, or disability per W&I Code Section 14029.91(e).

4. In accordance with 42 CFR 438.10(c)(6), if Contractor chooses to provide the required information electronically to Members, it must be: in a format that is readily accessible; in a location on Contractor's website that is prominent and readily accessible; and provided in an electronic form which can be electronically retained and printed. Readily accessible means electronic information and services which comply with modern accessibility standards such as section 508 guidelines, section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines 2.0 AA and successor versions. The information must be consistent with content and language requirements of 42 CFR 438.10 and ATTACHMENT 14: TEMPLATE INSTRUCTIONS. 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 five (5)

business days.

5. 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. Contractor must use the Member services guide developed by the State. 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, 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 SECTION 4. 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 about the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit and how to access component services if individuals under age twenty-one (21) entitled to the EPSDT benefit are enrolled. How and where to access any benefits provided by the state, including EPSDT benefits delivered outside the DMC plan, if any. Include information and identify services to which 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 Contractor, if applicable, and an explanation as to its use in authorizing or assisting Members to obtain services.

    d. Compliance with the following must be met through distribution of a provider directory, in accordance with 42 CFR 438.10(h) and Health and Safety Code Section 1367.27:

        1. The address and telephone number(s) of each service location (e.g., locations of hospitals, Primary Care Dentists (PCD), Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHCs) and Indian Health Care Providers (IHCP).

        2. 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 ages zero (0) to three (3), pregnant women and children with special health care needs.

3. Further, Contractor must make available in paper form (upon request) and electronic form, the following information about its network providers:

    a. The provider's name and practice locations.

    b. Telephone numbers

    c. Provider's office street address (es) and email address, if available.

    d. Type of practitioner.

    e. National Provider Identifier number.

    f. California license number and license type, of applicable.

    g. Specialty, including board certification or accreditation, if any.

    h. Website URL, as appropriate.

    i. Name(s) of each allied health care professional to the extent there is a direct contract for those services covered through the plan.

    j. Whether the provider will accept new members.

    k. 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.

    l. Whether the provider's office/ facility has accommodations for people with physical disabilities, including offices, exam room(s) and equipment.

4. The provider directory must include the information in the paragraph above for each of the provider types covered under the contract.

5. Information included in a paper provider directory must be updated at least monthly

and electronic provider directories must be updated no later than thirty (30) calendar days after Contractor receives updated provider information.

6. Provider directories must be made available on Contractor's Web site in a machine-readable file and format as specified by 42 CFR 438.10(h).

7. Contractor must maintain a publicly accessible standards-based provider directory (API) as described in 42 CFR section 431.70, which must include the information in this section d. Provider Directory. The provider directory APIs must meet the technical standards finalized in the federal Department of Health and Human Services, Office of the National Coordinator (ONC) 21st Century Cures Act final rule in 45 CFR section 170.215.

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. Definition of what constitutes an emergency dental condition and an emergency service. Procedures for obtaining emergency dental care (and that prior authorization is not required) 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 and alternative access standards as required by W&I code Section 14197.04.

k. Any restriction on the member's freedom of choice among network providers. The extent to which, and how members may obtain benefits form out-of-network providers.

l. Include information regarding member's rights and responsibilities, including the member's

right to:

1. Receive information on member and plan information.

2. Be treated with respect and with due consideration for his or her dignity and privacy.

3. Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.

4. Participate in decisions regarding his or her dental care, including the right to refuse treatment.

5. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.

6. Request and receive a copy of their dental records and request that they be amended or corrected.

m. 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.

n. Procedures for requesting an appeal or filing a grievance with Contractor, either verbally or in writing, including procedures to appeal decisions that deny, delay, or modify a Member's request for services. Include the toll-free telephone number a Member can use to file a grievance or request an appeal, and 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 timeframes to file a Grievance or request an Appeal, notification that an oral request for an Appeal should be followed by a written request for an Appeal and timelines for Contractor to acknowledge receipt of Grievances and Appeals, 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 Contractor will continue while the appeal or grievance is being resolved.

o. The causes for which a Member shall lose entitlement to receive services under this

Contract as stipulated in SECTION 4. DISENROLLMENT.

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

q. How to access auxiliary aids and services, including additional information in alternative formats and languages

r. The toll-free telephone number for member services

s. The toll-free telephone number for dental management (care coordination).

t. The toll-free telephone number for any other unit providing services directly to members.

u. Information on how to report suspected fraud or abuse.

v. Information on the Member's right to 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 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.

w. Information on the availability of, and procedures for obtaining, services at FQHC, RHCs, and IHCP.

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

y. 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).

z. 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.

aa. 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.

ab. An explanation of an American Indian Member's right not to be restricted in their access to IHCP by Contractor, and to disenroll from Contractor's plan at any time, without cause.

ac. A statement as to whether Contractor uses financial bonuses or other incentives to its Network Providers and that the Member may request additional information about these bonuses or incentives from the plan, the Member's Network Provider, or the Network Provider's medical group or independent practice association, pursuant to California Health and Safety Code, Section 1367.10.

ad. 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 Contractor without prior authorization.

7. Annual Member Reminder

During the Member's enrollment anniversary month, 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.

5. 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(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 an emergency or other unforeseeable circumstance, Contractor shall provide notice of the emergency or other unforeseeable circumstance to DHCS 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 fifteen (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. 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 thirty (30) days before the effective date of the policy consistent with 42 CFR 438.10(g)(4).

6. 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 IHCP 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.

7. 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, Contractor must take into consideration the age, location and linguistics of the Member and provider. 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 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 Contractor, respectively. Contractor shall provide to the PCD the address, phone number and all contact information the plan has on the Member.

8. 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 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 second (2^{nd}) 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 SECTION 3. 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 SECTION 3. 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. Contractor must mail the notice of adverse benefit determination at least ten (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. 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. 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. 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. 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. Contractor must give notice of adverse benefit determination on the date of determination when the action is a denial of payment.

EXHIBIT A15: MEMBER GRIEVANCE AND APPEAL SYSTEM

1. MEMBER GRIEVANCE AND APPEAL SYSTEM

Contractor shall have in place a Member Grievance and Appeal system in accordance with 28 CCR 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 Dental APL 22-006 and any future All Contractor Letters related to compliance with the Member Grievance and Appeal System.

2. GRIEVANCES

While state regulations do not specifically distinguish “grievances” from “appeals”, federal regulations define “grievance and appeal system” to mean the processes implemented by the Contractor to handle grievances and appeals, with the terms “grievance” and “appeal” each separately defined. Due to distinct processes delineated for the handling of each, Contractors must adopt the federal definition but also incorporate applicable sections of the existing state definition that do not pose conflicts.

1. 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 or care of 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 Contractor to make an authorization decision.

2. A complaint is the same as a grievance. Where Contractor is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.

3. An inquiry is a request for information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other Contractor processes.

4. Contractors must not discourage the filing of grievances. A Member need not use the term “grievance” for a complaint to be captured as an expression of dissatisfaction and processed as a grievance by the Contractor. If a Member expressly declines to file a grievance, the complaint shall still be categorized as a grievance and not an inquiry.

5. A Member or a provider or authorized Member working on their behalf may file a Grievance with the Contractor at any time either orally or in writing. Contractor shall provide written acknowledgement to the affected Member within five (5) calendar days of receipt of the Grievance. The acknowledgement letter must advise the Member that the grievance has been received, and the date of the receipt, and it must provide the name, telephone number, and

address of the representative who may be contacted about the grievance.

Contractor shall resolve the Grievance and provide notice to the affected Member no later than thirty (30) calendar days from the day Contractor receives the Grievance. The Contractor's written resolution must contain a clear and concise explanation of the decision. 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.

Even though federal regulations allow for a fourteen (14) calendar day extension for standard and expedited appeals, this allowance does not apply to grievances. In the event that resolution of a standard grievance is not reached within thirty (30) calendar days as required, the Contractor must notify the Member in writing of the status of the grievance and the estimated date of resolution.

6. Exempt Grievances

Contractors must comply with all state laws pertaining to exempt grievance handling. Grievances received over the telephone that are not coverage disputes, and are resolved by the close of the next business day, are exempt from the requirement to send a written acknowledgment and response. The Contractor must maintain a log of all such grievances containing the date of the call, the name of the complainant, Member identification number, nature of the grievance, nature of the resolution, and the name of the representative who took the call and resolved the grievance. The information contained in the log must be reviewed by the Contractor.

The Contractor must ensure exempt grievances are incorporated into the quarterly grievance and appeal report that is submitted to DHCS. Under federal regulations, coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment qualify as appeals and not grievances. Therefore, appeals are not exempt from written acknowledgment and resolution and must be processed as standard appeals.

7. Expedited Grievances

State law delineates processes for expedited grievance handling and require resolution within three calendar days. DHCS acknowledges that there are instances that may involve an imminent and serious threat to the health of a Member, including, but not limited to, severe pain, or impairment of bodily function that do not involve the appeal of an adverse benefit determination, yet are "urgent" or "expedited" in nature. For consistency, Contractors must apply the federal timeframe for resolving expedited appeals - seventy-two (72) hours - to expedited grievances. The seventy-two (72) hour timeframe requires Contractors to record not just the date of the grievance receipt, but also the time, as the specific time of receipt dictates the timeframe for resolution.

Federal regulations require Contractors to make reasonable efforts to provide the Member with oral notice of the expedited resolution. Contractors must apply this requirement of oral notice for expedited appeals to expedited grievances. Contractors must comply with all other state requirements pertaining to expedited grievance handling in accordance with state law.

3. APPEALS

An “appeal” is federally defined as a review by the Contractor of an adverse benefit determination. While state regulations do not explicitly define the term “appeal,” they do delineate specific requirements for certain types of grievances that would fall under the federal definition of appeal because they involve the delay, modification, or denial of services based on medical necessity, or a determination that the requested service is not a covered benefit. The Contractor must treat these grievances as appeals under federal regulations. Contractors must use the federal definition of “appeal” and comply with all existing state regulations as they pertain to the handling of appeals.

3.1. STANDARD APPEALS

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. Appeals filed by the provider on behalf of the Member require written consent from the Member. 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 sixty (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, except in instances of deemed exhaustion. Contractor shall have only one level of Appeal for Members.

    1. Contractors must accept a written appeal following the Member’s oral request for a standard appeal. However, Contractors only have thirty (30) calendar days to resolve the appeal regardless of whether the oral appeal is followed by a written appeal. If the Contractor fails to respond within thirty (30) calendar days of receipt of an oral request for an appeal, the Member is deemed to have exhausted the Contractor’s internal appeal requirement and can request a state hearing.

    2. Failure to submit a written appeal is not a basis for the Contractor to disregard the oral appeal. Contractors are required to assist any Member wishing to file an appeal. This includes assisting the Member with navigating the Contractor’s website or providing the appeal form to the Member upon request. Contractors must also advise and assist the Member to ensure the provision of Aid Paid Pending during the appeal of the adverse

benefit determination, in accordance with federal and state law. Contractors must provide Aid Paid Pending regardless of whether the Member makes a separate request to the Contractor when the Member timely files an appeal (i.e., within ten (10) days of the Notice of Action (NOA), or before the effective date of the intended action) of a decision to terminate, suspend or reduce services. In the event the Contractor does not receive a written, signed appeal from the Member, the Contractor is prohibited from dismissing or delaying the resolution of the appeal.

c. Contractor shall provide written acknowledgement to the affected Member within five (5) calendar days of receipt of the Appeal. The acknowledgment letter must advise the Member that the appeal has been received, the date of receipt, and it must provide the name, telephone number, and address of the representative who may be contacted about 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 thirty (30) calendar days from the day Contractor receives the Appeal. In the event Contractor fails to adhere to the state and federal notice timeframe requirements for either NOA or Notice of Appeal Resolution (NAR), including the Contractors failure to provide a fully translate notice, the Member is deemed to have exhausted Contractor's internal Appeal process and has the right to proceed to a State Fair Hearing.

3.2. EXPEDITED APPEALS

a. In accordance with federal law, the timeframe for resolving expedited appeals must be no longer than seventy-two (72) hours. Contractors must comply with the seventy-two (72) hour timeframe. The seventy-two (72) hour timeframe requires Contractors to record the time of appeal receipt, and not just the date, as the specific time of receipt dictates the timeframe for resolution. Additionally, Contractors are required to make reasonable efforts to provide the Member with oral notice of the expedited appeal resolution. Contractors must comply with all other existing state regulations pertaining to expedited appeal handling.

4. AUTHORIZATION TIMEFRAMES AND ADVERSE BENEFIT DETERMINATION

4.1. AUTHORIZATION TIMEFRAMES

Contractors must render a decision on a provider's request for authorization of dental care services for a Member, and notify the provider and the Member using the appropriate NOA template within the timeframes outlined below and in accordance with notification requirements in federal and state law. For purposes of auditing, the postmark on the Contractor's notice to the Member will be used to confirm compliance with all prior authorization request timeframes and notice requirements set forth below.

4.2. STANDARD REQUESTS

Contractors must approve, delay, modify, or deny a provider's prospective or concurrent request for dental services for a Member within the shortest applicable timeframe which is appropriate for the Member's condition, but no longer than five business days from the Contractor's receipt of information reasonably necessary and requested by the Contractor to make a determination, not to exceed fourteen (14) calendar days following the Contractor's receipt of the request for service. Decisions to approve, modify, or deny requests, must be communicated by the Contractor to the provider within twenty-four (24) hours of the decision and to the Member within two business days using the appropriate NOA template. The Contractor's written notice to the Member must also be sent with sufficient time to allow the Member to request Aid Paid Pending (i.e., continuation of benefits), if applicable.

Federal law permits an extension of the initial fourteen (14) calendar day authorization timeframe by up to fourteen (14) days if the Member or the provider requests an extension, or if the Contractor can justify its need for additional information and demonstrate how the extension is in the Member's interest.

If the Contractor requires an extension of the initial fourteen (14) calendar day authorization timeframe, the Contractor must either deny the authorization request or immediately notify the requesting provider to request all specific information the Contractor still needs to make its authorization decision. The Contractor must also document its justification in the Member's medical record of the need for the extension to obtain additional information and demonstrate how the extension is in the Member's interest. Contractors must provide this documentation to DHCS upon request.

The Contractor's written notice requesting additional information must specify the information the Contractor requested but did not receive, the expert reviewer to be consulted, or the additional examinations or tests required before the service can be approved or denied.

The Contractor must also include the anticipated date when its decision will be made, make a decision on the request as expeditiously as the Member's health condition requires, and advise the Member that they have a right to file a grievance to dispute the delay. The Contractor must send this written notice within the required timeframe, or as soon as the Contractor becomes aware that it will not meet the initial authorization timeframe, whichever is earlier. Following the Contractor's notification and request for additional and specific information, the Contractor must approve, delay, modify, or deny a provider's retrospective request within the shortest applicable timeframe that is appropriate for the nature of the Member's condition, but no longer than five business days from the Contractor's receipt of information reasonably necessary and requested by the Contractor to make a determination, not to exceed the additional fourteen (14) calendar days.

Decisions to approve, modify, or deny requests, must be communicated by the Contractor to the provider within twenty-four (24) hours of the decision and to the Member within two (2) business days using the

appropriate NOA template.

A Contractor's failure to render a decision for standard authorization requests within the required timeframes above is considered a denial and therefore constitutes an adverse benefit determination on the date that the timeframe expires. In this situation, the Member has the right to request an appeal with the Contractor and the Contractor must send the Member written notice of all appeal rights.

4.3. EXPEDITED REQUESTS

In instances where a provider indicates, or the Contractor determines, that the standard request timeframe may seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, the Contractor must approve, modify, or deny a providers prior authorization or concurrent request causing severe pain or impairing function, the Contractor must approve, delay, modify, or deny a provider's prior authorization or concurrent request for dental services for a Member, and notify the provider and the Member, using the appropriate NOA template, in a timeframe which is appropriate for the nature of the Member's condition, but is no longer than seventy-two (72) hours after the Contractor's receipt of all information needed to make an authorization decision for the request for service.

Federal law permits an extension of the initial seventy-two (72) hour authorization timeframe by up to fourteen (14) calendar days if the Member requests the extension, or upon DHCS satisfaction, the Contractor can justify its need for additional information and can demonstrate how the extension is in the Member's best interest.

If the Contractor requires an extension of the initial seventy-two (72) hour authorization timeframe, the Contractor must either deny the authorization request or document its justification in the Member's medical record of the need for the extension to obtain additional information and demonstrate how the extension is in the Member's interest. If the Contractor requires the extension, it must send written notice to the Member and the provider, using the appropriate NOA template, to request the specific information it needs to determine if the service is medically necessary. This notice must be sent within the required timeframe, or as soon as the Contractor becomes aware that it will not be able to meet the initial timeframe, whichever is earlier.

The written notice must specify the information the Contractor needs but did not receive, the expert reviewer to be consulted, or the additional examinations or tests required before the service can be approved or denied. The Contractor must also include the anticipated date when its decision will be made, make a decision on the request as expeditiously as the Member's health condition requires, and advise the Member that they have a right to file a grievance to dispute the delay.

Following this notification and request for specific information, the Contractor must approve, modify, or deny the request within the shortest applicable timeframe that is appropriate for the nature of the

Member's condition, but is no longer than seventy-two (72) hours from the Contractor's receipt of the additional information reasonably necessary and requested by the Contractor to make a determination, not to exceed the additional fourteen (14) calendar days. The Contractor's written response to the Member must be sent with sufficient time to allow the Member to request Aid Paid Pending, if applicable.

A Contractor's failure to render a decision for standard authorization requests, within the required timeframes above is considered a denial and therefore constitutes an adverse benefit determination on the date that the timeframe expires.

In this situation, the Member has the right to request an appeal with the Contractor and the Contractor must send the Member written notice of all appeal rights.

4.4. RETROSPECTIVE REQUESTS

In cases where the review is retrospective, the Contractor must communicate its decision to the Member who received services, or to the Member's designee, within thirty (30) days of the receipt of information that is reasonably necessary to make the retro-authorization determination. The Contractor is also required to communicate the decision to the provider in a manner that is consistent with current law.

4.5. SUSPENSIONS OR REDUCTIONS

For suspensions or reductions of previously authorized services, Contractors must notify Members at least ten days prior to the date of the action pursuant to Title 42 CFR section 431.211 to ensure there is adequate time for Members to timely file for Aid Paid Pending, with the exception of circumstances permitted under Title 42, CFR, sections 431.213 and 431.214.

5. NOTICE OF ADVERSE BENEFIT DETERMINATION

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. A denial, in whole or in part, of a payment for service solely because the claim does not meet the definition of a "clean claim" per 42 CFR section 447.45(b) is not an adverse benefit determination.

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.

7. For a resident of a rural area with only one Contractor, the denial of the Member's request to obtain services outside the network.

6. NOTICE OF ACTION

Contractors must provide Members with written notice of an adverse benefit determination using the DHCS-developed, standardized NOA template and the NOA "Your Rights" template. The following four distinct NOA templates accommodate actions that Contractors may commonly take:

1. Denial of a treatment of service;

2. Delay of a treatment or service;

3. Modification of a treatment or service;

4. Suspension or reduction of the level of treatment or service currently underway;

Contractors are not permitted to make any changes to the NOA templates or NOA "Your Rights" templates without prior review and approval from DHCS, except to insert information specific to the Member as required.

7. CONTENTS OF THE NOTICE

Content requirements of the NOA are delineated in federal and state law. The written NOA must meet all language and accessibility standards, including translation, font, and format requirements, as set forth in Dental APL 21-001, Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services, federal and state law, and all requirements in the DHCS Contract.

The NOA is comprised of two components: 1) the appropriate DHCS standardized NOA template and 2) The DHCS standardized NOA "Your Rights" template. Contractors are required to send the documents together any time a NOA is issued.

7.1. WRITTEN NOTICE OF AN ADVERSE BENEFIT DETERMINATION (NOA

TEMPLATE)

Contractors must comply with all federal and state law in determining whether to approve, modify, or deny requests by providers prospectively, concurrently, or retrospectively. Members may request, free of charge, copies of all documents and records the Contractor relied on to make decisions, including any clinical criteria or guidelines used. For decisions based in whole or in part on medical necessity, the written NOA must contain all of the following:

a. A statement of the action the Contractor intends to take.

b. A clear and concise explanation of the reasons for the decision.

c. A description of the criteria or guidelines used. This includes a reference to the specific regulation or authorization procedure(s) that supports the decision, as well as an explanation of the criteria or guidelines.

d. The clinical reasons for the decision. The Contractor must explicitly state how the Member's condition does not meet the criteria or guidelines

e. For written notification to the provider, the name and direct telephone number or extension of the decision maker. Decisions must be communicated to the Member in writing. In addition, with the exception of decisions rendered retrospectively, decisions must be communicated to the provider initially by telephone or facsimile, and also in writing.

   If the Contractor can substantiate through documentation that effective processes are in place to allow the provider to easily contact the decision maker through means other than a direct phone number (e.g., telephone number to the specific unit of the Utilization Management Department that handles provider appeals directly), a direct telephone number or extension is not required. However, the Contractor must conduct ongoing oversight to monitor the effectiveness of this process.

   Requirements 'a' through 'e' above only pertain to decisions based in whole or in part on medical necessity. For all other adverse benefit determinations that are not based on medical necessity (e.g. Denials based on a lack of information, or benefit denials, etc.), DMC must still ensure that the NOA provides a clear and concise explanation of the reasons for the decision.

7.2. NOA "YOUR RIGHTS" TEMPLATE(S)

The NOA "Your Rights" attachment informs Members of critical appeal and hearing rights.

Federal and state law require that Members exhaust the Contractor's internal appeal process and receive notice that the adverse benefit determination has been upheld prior to proceeding to a state hearing. However, if the Contractor fails to adhere to federal and state notice and timeframe requirements, the Member is deemed to have exhausted the Contractor's internal appeal process and may request a state hearing.

The DHCS-developed NOA "Your Rights" attachment template includes all of the following required elements:

a. The Member's or provider's right to request an internal appeal with the Contractor within sixty (60) calendar days from the date on the NOA.

b. The Member's right to request a state hearing after filing an internal appeal with the Contractor and receiving notice that the adverse benefit determination has been upheld.

c. The Member's right to request a state hearing without having to exhaust the Contractor's internal appeal process, in instances of deemed exhaustion.

d. Procedures for exercising the Member's rights to request an appeal.

e. Circumstances under which an expedited review is available and how to request one.

f. The Member's right to Aid Paid Pending and instructions on how to timely file for an appeal (i.e., within ten (10) days of the NOA or before the effective date of the intended action) of a decision to terminate, suspend or reduce services. Contractors must provide Aid Paid Pending regardless of whether the Member makes a separate request to the Contractor when the Member timely files an appeal of a decision to terminate, suspend or reduce services.

   Contractors must use the NOA "Your Rights" templates enclosed to this Dental APL. The NOA "Your Rights" template for Knox-Keene licensed Contractors provides information for Members about how to request an Independent Medical Review (IMR). Knox-Keene licensed Contractors are subject to additional state laws, including the requirement that certain written notices to Members contain prescribed language advising Members of additional rights and directing them to contact the Department of Managed Health Care (DMHC) to request an IMR. This required mandatory paragraph is already incorporated into the template and requires no action by the Contractors

   When sending the "Your Rights" attachment to Members as part of the NOA, Contractors must include the most current version of the state hearing form enclosed with this Dental APL. Knox-Keene licensed Contractors must also include the IMR form, application instructions, DMHC's toll-

free telephone number, and an envelope addressed to DMHC. Knox-Keene licensed Contractors are required to check the DMHC website periodically to ensure use of the most current IMR form. Contractors may include state hearing and IMR forms that contain tracking numbers to more easily identify and administer Member rights. Such tracking numbers should contain initials, acronyms, or names that identify the Contractor.

7.3. CONTENT OF NOTICE

Content requirements for the NAR are delineated in federal and state law. The written NAR must meet all language and accessibility standards, including translation, font, and format requirements, as set forth in Dental APL 21-001, Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services, federal and state law, and all requirements in the DHCS Contract.

For appeals not resolved wholly in favor of the Member, the NAR is comprised of two components: 1.) The NAR “Uphold” template and 2.) The NAR “Your Rights” template. Contractors must send the Member both of these documents to comply with all requirements of the NAR.

For appeals resolved in favor of the Member, the NAR only consists of the NAR “Overturned” template; the “Your Rights” attachment is not included with the NAR when the appeal overturns the original adverse benefit determination.

8. NOTICE OF APPEAL RESOLUTION

A NAR is a formal letter from a Contractor informing a Member of the outcome of the appeal of an adverse benefit determination. The NAR informs the Member whether the Contractor has overturned or upheld its decision on the adverse benefit determination.

1. 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. There are two NAR template options:

    a. Uphold: for appeals not resolved wholly in favor of the Member; or

    b. Overturned: for appeals resolved in favor of the Member

2. For appeals upholding the original adverse benefit determination, the NAR must also include the NAR “Your Rights” attachment. Contractors are not permitted to make any changes to the NAR templates or “Your Rights” templates without prior review and approval from DHCS, except to insert information specific to the Member as required. Contractors must comply with federal and state law in determining whether to uphold or overturn an adverse benefit determination in

response to Member appeals. The written NAR must contain the following:

a. The results of the resolution and the date it was completed.

b. For decisions to uphold a denial determination that is based in whole or in part on medically necessity, the reasons for its determination and clearly stated criteria, clinical guidelines, or dental policies used in reaching the determination.

c. For decisions to uphold a denial based on a determination that the requested service is not a covered benefit, the provision in the DHCS Contract, or in the evidence of coverage/ Member handbook, that excludes the service. The response must either identify the document and page where the provision can be found, direct the Member to the applicable section of the Contract containing the provision, or provide a copy of the provision and explain in clear concise language how the exclusion applied to the specific dental service or benefit requested.

d. For appeals resolved in favor of the Member: a clear and concise explanation of why the decision was overturned.

e. For Appeals not resolved wholly in favor of the Member, the NAR shall include a “cc” to DHCS either by USPS mail, or electronically to dentalmanagedcare@dhcs.ca.gov.

3. NAR “Your Rights” Attachment Template(s)

The NAR “Your Rights” template informs Members of their rights following an adverse benefit determination that has been upheld on appeal. It does not contain information on how to file a request for an appeal, as the Member will have already exhausted the Contractor’s appeal process.

The DHCS-developed NAR “Your Rights” templates include all of the following elements:

a. The Member’s right to request a state hearing no later than one hundred twenty (120) calendar days from the date of the Contractors written NAR and instructions how to request a state hearing.

b. The Members right to Aid Paid Pending and instructions on how to timely file for a state hearing (i.e., within ten (10) days of the NAR) regarding a decision to terminate, suspend or reduce services. Contractors must provide Aid Paid Pending regardless of whether the

Member makes a separate request to the Contractor when the Member timely files for a state hearing regarding a decision to terminate, suspend or reduce services.

c. For Knox-Keene licensed Contractors, the Member's right to request an IMR from the DMHC if the Contractor's determination is based in whole or in part that the service is not medically necessary, is experimental/investigational, or is a disputed emergency service.

   Contractors must use the NAR "Your Rights" templates enclosed with this Dental APL. The NAR "Your Rights" template for Knox-Keene licensed Contractors provides information for Members on how to request an IMR. Knox-Keene licensed Contractors are subject to additional state laws, including the requirement that certain written notices to Members contain prescribed language advising Members of additional rights and directing them to contact DMHC to request an IMR. This mandatory paragraph is already incorporated into the template and requires no action by Contractors. When sending the "Your Rights" attachment to Members as part of the NAR, Contractors must include the most current version of the state hearing form, which is provided as an attachment to this Dental APL. Knox-Keene licensed Contractors must also include the IMR form, application instructions, DMHC's toll-free telephone number, and an envelope addressed to DMHC. Knox-Keene licensed Contractors are required to check the DMHC website periodically to ensure use of the most current form. Contractors may include state hearing and IMR forms that contain tracking numbers to more easily identify and administer Member rights. Such tracking numbers should contain initials, acronyms, or names that identify the Contractor.

9. OVERTURNED DECISIONS

Contractors must authorize or provide the disputed services promptly and as expeditiously as the Member's condition requires if the Contractor reverses its decision to deny, limit, or delay services that were not furnished while the appeal was pending. Contractors shall authorize or provide services no later than seventy-two (72) hours from the date the determination is reversed.

9.1. TRANSLATION OF GRIEVANCE AND APPEAL NOTICES

Federal and state law, the DHCS Contract, and Dental APL 21-001 require Contractors to fully translate and provide written Member information in a Member's required language, as specified, including all grievance and appeals notices referenced in this Dental APL.

Specifically, Contractors must fully translate NOAs/NARs, including the clinical rationale for the Contractor's decision that must be included in the NOA/NAR. While DHCS has made it clear that immediate translation of the entire NOA/NAR is required by federal and state law, DHCS acknowledges that Contractor Trade Associations have advised that some Contractors do not currently have sufficient

technological or Contractual processes in place to ensure immediate translation of the clinical rationale.

Contractors that are not currently in compliance with immediate, full translation of the entire NOA/NAR are expected to come into compliance with full translation within six (6) months of the issuance date of this Dental APL. Failure to come into compliance will subject non-compliant Contractors to corrective action and imposition of monetary sanctions.

Contractors that mail a partially translated NOA/NAR with the clinical rationale written in English must ensure all of the following requirements are met during the six (6) month compliance period: 1) the body of the NOA/NAR (i.e., non-clinical NOA/NAR template language) must be translated into the Member's required language; 2) a sentence must be inserted in the NOA/NAR in the Member's required language explaining how the Member can obtain oral interpretation of the clinical rationale on an expedited basis; 3) the Contractor must make every effort to provide the Member with an explanation of the clinical rationale regarding the requested service, which includes assisting the Member in exercising all grievance rights pursuant to federal and state law; 4) provide a fully translated written notice, including a fully translated clinical rationale, as soon as possible but not later than thirty (30) calendar days from the date the partially translated notice was sent; and, 5) the Contractor is prohibited from requesting dismissal of a state hearing in all cases where it failed to provide a fully translated notice because this qualifies as deemed exhaustion of the Contractor's internal appeal and the Member can immediately request a state hearing.

10. STATE HEARINGS

A Member has a due process right to request a state hearing when a claim for medical assistance is denied or is not acted upon with reasonable promptness. A Member may also initiate a state hearing if the Member is deemed to have exhausted the Contractor's appeal process because the Contractor failed to comply with notice and timing requirements. The parties to a state hearing include the Contractor as well as the Member and, if applicable, the Member's representative or the representative of a deceased Member's estate. To ensure a Member's right to due process during the state hearing process, the Contractor must ensure that a statement of position is timely filed with the California Department of Social Services (DSS) State Hearings Division and that a witness is available and prepared to present the Contractor's position and to be cross examined at the state hearing. In addition, the Contractor shall ensure compliance with all DHCS-issued policies regarding all threshold language or alternative format requirements, including those as requested by the Member or the Member's representative.

1. Timeframes for Filing Federal regulations require Members to request a state hearing no less than 90 calendars days and no more than 120 calendar days from the date of the NAR, informing the Member that an adverse benefit decision has been upheld. The DHCS templates for the "Your Rights" attachments inform Members of this requirement. In cases of deemed exhaustion, the Member has one hundred twenty (120) days from: 1) the expiration date of the timeframe in which the Contractor should have sent a NAR to the Member; 2) the expiration date of the timeframe in

which the Contractor should have sent a NOA to the Member; or 3) the date of the Member's receipt of the Contractor's deficient written NAR/NOA (e.g., in cases where the Contractor failed to provide a fully translated NOA).

2. Standard Hearings. The Contractor must notify Members that the state must issue a final decision within ninety (90) calendar days of the date of the request.

3. Expedited Hearings. The Contractor must notify Members that the state must issue a final decision within three working days of the date of the request.

4. Overturned Decisions. The Contractors must authorize or provide the disputed services promptly and as expeditiously as the Member's health condition requires, no later than seventy-two (72) hours from the date the Contractor receives notice of the hearing decision reversing the Contractor's adverse benefit determination.

5. Nondiscrimination notice and language assistance taglines

   When sending the required grievance and appeals notifications to Members, Contractors must comply with the nondiscrimination and language assistance requirements as outlined in Dental APL 21-001, including any subsequent updates or revisions to this Dental APL.

11. GRIEVANCE AND APPEAL SYSTEM OVERSIGHT

Contractors must establish, implement, maintain, and oversee a grievance and appeal system to ensure the receipt, review, and resolution of grievances and appeals. The grievance and appeal system must operate in accordance with all applicable federal, and state laws.

1. The Contractor must operate in accordance with its written procedures for grievance and appeals. These procedures must be submitted to DHCS prior to use.

2. The Contractor must designate an officer that has primary responsibility for overseeing the grievance and appeal system. The officer must continuously review the operation of the grievance and appeal system to identify any emergent or systemic issues with grievance and appeals and/or patterns of improper service denials. The grievance and appeal system must include reporting procedures in order to improve Contractor's policies and procedures.

3. The Contractor must notify Members about its grievance and appeal system and shall include information for Members on how the Contractor's procedures for filing and resolving grievances and appeals work, a toll-free telephone or a local telephone number in each service area, and the address for mailing grievances and appeals. The notice must also include information regarding

DMHC's review process, the IMR system, and DMHC's toll-free telephone number and website address, as appropriate.

4. The Contractor must notify Members of the process for obtaining grievance and appeals forms. A description of the procedure for filing grievances and appeals must be readily available at each facility of the Contractor, on the Contractor's website, and at each Contracting provider's office or facility. The Contractor must ensure that assistance in filing grievances and appeals will be provided at each location where grievances and appeals are submitted. Grievance and appeal forms must be provided promptly upon request.

5. The Contractor must ensure adequate consideration of grievances and appeals and rectification when appropriate. If multiple issues are presented by the Member, the Contractor must ensure that each issue is addressed and resolved.

6. The Contractor must maintain a written record for each grievance and appeal received by the Contractor. The record of each grievance and appeal must be maintained in a log and include the following information:

    a. The date and time of receipt of the grievance or appeal.

    b. The name of the Member filing the grievance or appeal.

    c. The representative recording the grievance or appeal.

    d. A description of the complaint or problem.

    e. A description of the action taken by the Contractor or provider to investigate and resolve the grievance or appeal.

    f. The proposed resolution by the Contractor or its medical professional responsible for making utilization management decisions.

    g. The name of the Contractor provider or staff responsible for resolving the grievance or appeal.

    h. The date of notification to the Member of resolution.

7. As required in DHCS Contract SECTION 12. GRIEVANCE AND APPEAL LOG AND QUARTERLY GRIEVANCE AND APPEAL REPORT, the Contractor shall submit quarterly

grievance and appeal reports in the required 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 written record of grievances and appeals must be submitted, at least quarterly to the Contractor's quality assurance committee for systematic aggregation and analysis for quality improvement. Grievances and appeals reviewed must include, but not be limited to, those related to access to care, quality of care, and denial of services. Contractors must take appropriate action to remedy any problems identified.

8. The written record of grievances and appeals must be reviewed periodically by the governing body of the Contractor, the public policy body, and by an officer of the Contractor or designee. The review must be thoroughly documented.

9. The Contractor must ensure the participation of individuals with authority to require corrective action. All grievances and appeals related to dental quality of care issues shall be immediately submitted to the Contractor's dental director for action.

10. The Contractor must address the linguistic and cultural needs of its Member population as well as the needs of Members with disabilities. The Contractor must ensure all Members have access to and can fully participate in the Grievance and Appeal System by assisting those with limited English proficient Members or those with a visual or other communicative impairment. Such assistance includes, but is not limited to, translations of grievance and appeal procedures, forms, and Contractor responses to grievances and appeals, as well as access to interpreters, telephone relay systems and other devices that aid disabled individuals to communicate.

11. The Contractor must assure that there is no discrimination against a Member on the grounds that the Member filed a grievance or appeal.

12. The Contractor must establish and maintain a system of aging grievances and appeals that are pending and unresolved for thirty (30) calendar days or more and include a brief explanation of the reasons for each pending and unresolved grievance and each appeal.

13. The Contractor must 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. Additionally, the decision maker must be a dental professional with clinical expertise in treating a Member's condition or disease if any of the following apply:

    a. An appeal of an adverse benefit determination that is based on lack of medical necessity.

    b. A grievance regarding denial of an expedited resolution of an appeal.

c. Any grievance or appeal involving clinical issues.

14. The Contractor must ensure that individuals making decisions on clinical appeals take into account all comments, documents, records, and other information submitted by the Member or Member's designated representative, regardless of whether such information was submitted or considered in the initial adverse benefit determination.

15. The Contractor must provide the Member or Member's designated representative the opportunity to review the Member's case file, including dental records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the Contractor in connection with any standard or expedited appeal of an adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe.

16. The Contractor shall provide the Member a reasonable opportunity, in person and in writing, to present evidence and testimony. The Contractor must inform the Member of the limited time available for this sufficiently in advance of the resolution timeframe.

12. 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), 28 CCR 1300.68(b)(5), 42 CCR 438.416(b) 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 and 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.

13. 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 Member's estate.

EXHIBIT A16: ENROLLMENTS AND DISENROLLMENTS

1. ENROLLMENT PROGRAM

Contractor shall cooperate with the DHCS enrollment program and shall provide to DHCS' Enrollment Contractor a list of network providers (provider directory), linguistic capabilities of the providers and other information deemed necessary by DHCS to assist 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.

2. ENROLLMENT

Contractor shall accept as Members, Medi-Cal beneficiaries in the mandatory and voluntary aid categories as defined in EXHIBIT E1: 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.

2.1. 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, or identification with any other persons or groups defined in Penal Code 422.56.

2.2. 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. Enrollment shall continue indefinitely unless this Contract expires, is terminated, or the Member is disenrolled under the conditions described in SECTION 4. DISENROLLMENT.

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.

2.3. EXCEPTION TO ENROLLMENT

An eligible Member 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.

2.4. 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.

2.5. ENROLLMENT CAPACITY

All eligible Members shall be accepted by Contractor up to the limits of Contractor's enrollment capacity approved by DHCS.

2.6. REENROLLMENT

DHCS will automatically reenroll an eligible beneficiary who was disenrolled because the beneficiary lost Medicaid eligibility for a period of two (2) months or less.

2.7. ENROLLMENT DISCRIMINATION PROHIBITED

a. The Contractor shall 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 CFR § 438.50(a).

c. The Contractor shall not, on the basis of health status or need for health care services, discriminate against individuals eligible to enroll.

d. The Contractor 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).

3. CONTINUANCE OF MEMBERSHIP

A Member's enrollment shall continue unless this Contract is terminated, or the Member is disenrolled under the conditions described in SECTION 4. 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 Plans, and without a break in service, receives a new Contract. Notwithstanding this Provision 3, each Member maintains the right to change dental plans at any time.

4. DISENROLLMENT

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. The Enrollment Contractor shall process a Member disenrollment under the following conditions, 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 SECTION 4. WRITTEN MEMBER INFORMATION, Subprovision 5, Paragraphs o and p.

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 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 in accordance with 42 CFR 438.56(b)(2).

3. 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. 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. 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. 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. 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.

5. 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 A17: MARKETING

1. TRAINING AND CERTIFICATION OF MARKETING REPRESENTATIVES

Contractor shall develop a training and certification program for marketing representatives, as described in this Exhibit, 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 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 identification with any other persons or groups defined in Penal Code 422.56.

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 Member 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.

2. 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.

3. MARKETING PLAN

If Contractor conducts marketing, Contractor shall develop a marketing plan as specified below. The marketing plan shall be specific to the Medi-Cal Dental Managed Care Plans 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 forty-five (45) calendar days before the end 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. If the Contractor does not conduct marketing activities, Contractor should submit a formal letter stating that it will not be conducting marketing activities for the reporting period.

    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, e-mail, texting or other marketing for the purpose of enrolling Members.

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 A18: DELIVERABLE SCHEDULE

Dental Managed Care Deliverables – Due Calendar Year (CY) 2023

Deliverable	Reference	Submission Guideline
ANNUAL (23)		
Annual Financial Statement (CPA Audited)	Exhibit A3, SECTION 3. INDEPENDENT FINANCIAL AUDIT REPORTS	120 days after the end of the Calendar Year (CY) and Fiscal Year (FY)
Annual Financial Statement (DMHC)	Exhibit A3, SECTION 2. CONTRACTOR'S FINANCIAL REPORTING OBLIGATIONS Subsection 4	120 days after the end of the CY/FY
Annual Forecasts	Exhibit A3, SECTION 2. CONTRACTOR'S FINANCIAL REPORTING OBLIGATIONS Subsection 5	60 days prior to the beginning of the CY/FY
Annual Financial Statement (Medi-Cal Only)	Dental APL 15-004; Dental APL13-002; Exhibit A3, SECTION 2. CONTRACTOR'S FINANCIAL REPORTING OBLIGATIONS Subsection 4	120 days after the end of the CY/FY
Annual Member Reminder	Exhibit A14, SECTION 4. WRITTEN MEMBER INFORMATION, Subsection 7	30 days after the beginning of the CY
Consumer Satisfaction Survey	Dental APL 14-004; Exhibit A5, SECTION 10.3. CONSUMER SATISFACTION SURVEY	30 days after the end of the CY
Consumer Satisfaction Survey	Dental APL 14-004;	Methodology due 90 days

Methodology	Exhibit A5, SECTION 10. EXTERNAL QUALITY REVIEW REQUIREMENTS, Subsection 3	prior to December 31 of each CY
EPSDT Policy & Procedure	Dental APL 19-001; Exhibit A12, SECTION 3. SERVICES FOR MEMBERS UNDER 21 YEARS OF AGE	30 days after the beginning of the CY
EQRO Performance Measure Audit (GMC & PHP)	Dental APL 22-015; Exhibit A5, SECTION 10. EXTERNAL QUALITY REVIEW REQUIREMENTS	120 days after the end of the CY
Health Education Programs	Dental APL 13-013; Exhibit A12, SECTION 4. SERVICES FOR ALL MEMBERS, Subsection 1	30 days after the beginning of the CY
Initial Screening Policy and Plan-Specific OHI Form	Dental APL 18-007; EXHIBIT A13: CASE MANAGEMENT AND COORDINATION OF CARE	30 days after the beginning of the CY and any changes within 10 Calendar Days
Key Personnel Disclosure Form	Exhibit A2, SECTION 2. KEY PERSONNEL (DISCLOSURE FORM)	30 days after the beginning of the CY
Marketing Plan	Dental APL 13-010;	30 days after the beginning of the CY
Member Handbook (EOC)	Dental APL 17-002; Exhibit A14, SECTION 4. WRITTEN MEMBER INFORMATION, Subsection 5	30 days after the beginning of the CY
Member Incentive Report	Dental APL 18-009	Long term (more than 6

		months): 60 days after the program start and annually on this anniversary date; Short term (6 months or less): 60 days after the program completion
Overpayment Recoveries	Dental APL 22-003E, Exhibit E, SECTION 28. FRAUD, WASTE AND ABUSE, Subsection 4	60 days after the end of the CY
Policy and Procedure for *detecting* Fraud, Waste and Abuse	Dental APL 22-010	30 days after the end of the CY
Policy and Procedure for *reporting* Fraud, Waste and Abuse	Dental APL 22-010	30 days after the end of the CY
Program Integrity	Dental APL 22-010; Exhibit E, SECTION 21. MONITORING REQUIREMENTS	30 days after the end of the CY
Quality Improvement Annual Report + Plan Accreditation	Dental APL 18-002; Exhibit A5, SECTION 9. QUALITY IMPROVEMENT AND ORAL HEALTH ACCESSANNUAL PLAN	30 days after the beginning of the CY
Time and Distance	Dental APL 17-008; Exhibit A8, SECTION 6. TIME AND DISTANCE STANDARD	30 days after the beginning of the CY
Transition of Care Policy	Dental APL 17-011E; Exhibit A13, SECTION 1. CASE MANAGEMENT SERVICES	30 days after the beginning of the CY

Utilization Data Report	Dental APL 13-006; Exhibit A7, SECTION 4. REVIEW OF UTILIZATION DATA	30 days after the beginning of the CY
QUARTERLY (13)		
Call Center Report	Dental APL 20-004; Exhibit A14, SECTION 3. CALL CENTER REPORTS	30 days after the end of the CY quarter
Case Management	Dental APL 22-015; Exhibit A13, SECTION 1. CASE MANAGEMENT SERVICES	30 days after the end of the CY quarter
Grievance & Appeal Report	Dental APL 22-006; Dental APL 20-003; Dental APL 18-001; Dental APL 17-012; EXHIBIT A15: MEMBER GRIEVANCE AND APPEAL SYSTEM	30 days after the end of the CY quarter
Linguistic Services Report	Dental APL 20-004; Exhibit A11, SECTION 7. CULTURAL AND LINGUISTIC PROGRAM	30 days after the end of the CY quarter
Performance Measures	Dental APL 22-015; Dental APL 22-002; Dental APL 18-006; EXHIBIT A6: PERFORMANCE MEASURES AND BENCHMARKS	60 days after the end of the CY quarter (30 days contractually and an additional 30 days for administrative processing)
Prop 56 Directed Payments	Dental APL 22-012	45 days after the end of the CY quarter
Provider Monitoring Report	Exhibit A5, SECTION 12.6. CONTINUING OVERSIGHT	30 days after the end of the CY quarter

Provider Training	Dental APL 13-014; Exhibit A9, SECTION 5. NETWORK PROVIDER TRAINING	30 days after the end of the CY quarter
QIP Reports	Dental APL 18-002; Exhibit A5, SECTION 8. QUALITY IMPROVEMENT PROJECTS (QIPS)	30 days after the end of the CY quarter
Quarterly Financial Statement (DMHC)	Dental APL 13-001; Exhibit A3, SECTION 2. CONTRACTOR'S FINANCIAL REPORTING OBLIGATIONS Subsection 3	45 days after the end of the CY
Quarterly Financial Statement (Medi-Cal Only)	Dental APL 13-001; Exhibit A3, SECTION 2. CONTRACTOR'S FINANCIAL REPORTING OBLIGATIONS Subsection 3	45 days after the end of the CY quarter
Quality Improvement Committee Meeting Minutes	Exhibit A5, SECTION 4. QUALITY IMPROVEMENT AND ORAL HEALTH ACCESSCOMMITTEE (QIOHAC)	120 days after the end of the CY quarter
Timely Access and Specialty Referral Report	Dental APL 18-003 Exhibit A11, SECTION 2.2. WAITING TIMES, SECTION 2.3. TELEPHONE PROCEDURES, SECTION 2.5. SPECIALTY SERVICES	120 days after the end of the CY quarter
MONTHLY (8)		

Monthly Financial Statement (Medi-Cal Only)	Exhibit A3, SECTION 2. CONTRACTOR'S FINANCIAL REPORTING OBLIGATIONS Subsection 2	30 days after the close of Contractor's fiscal month
Encounter Data (and EDSRF)	Dental APL 18-011; Dental APL 15-007; Exhibit A4, SECTION 2. ENCOUNTER DATA SUBMITTAL	15 days after the end of the month
Member Phone Call Report	Exhibit A14, SECTION 2. MEMBER SERVICES STAFF, Subsection 5	30 days after the end of the month
Provider Directory	Dental APL 22-015; Dental APL 22-013; Exhibit A14, SECTION 4. WRITTEN MEMBER INFORMATION, Subsection 5.d	15 days after the end of the month
[PNR] Plan Provider Network Report	Dental APL 19-004; Dental APL 17-010; Dental APL 13-008; Exhibit A8, SECTION 7. NETWORK PROVIDER AVAILABILITY, SECTION 8. PROVIDER NETWORK REPORTS, Exhibit A10, SECTION 6. PROHIBITED CLAIMS AND PAYMENTS	15 days after the end of the month
Self-Reported Monthly Utilization Data (PCD)	Dental APL 22-015; Dental APL 13-006; Exhibit A7, SECTION 4. REVIEW OF UTILIZATION DATA	60 days after the end of the month

[TAR] Treatment Authorization Request Submission	Dental APL 22-006; Dental APL 20-004;	30 days after the end of the month

Deliverable Templates

Contractor shall use the templates developed by DHCS in this attachment for submitting specific deliverables. If Contractor does not meet the Contract Requirements for any of the reported deliverables, Contractor must include with their deliverable a Corrective Action Plan (CAP) which must identify: The specific deficiency, the causation of the deficiency, description of the corrective steps taken or will be taken to remedy the deficiency, supporting documentation (such as evidence of corrections made), contact person(s); and implementation dates

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 A3, Provision 2, Sub provision 4)

REPORT #2: REVENUE, EXPENSES AND NET WORTH

		Sacramento		Los Angeles		Total	
		1	2	1	2	1	2
		Current Period	YTD	Current Period	YTD	Current Period	YTD
Revenues:							
1.	Premiums (Commercial)	-	-	-	-	-	-
2.	Capitation	-	-	-	-	-	-
3.	Co-payments, COB, Subrogation	-	-	-	-	-	-
4.	Title XVIII - Medicare	-	-	-	-	-	-
5.	Title XIX - Medicaid	-	-	-	-	-	-
6.	Fee-For-Service	-	-	-	-	-	-
7.	Point-Of-Service (POS)	-	-	-	-	-	-
8.	Interest	-	-	-	-	-	-
9.	CA State Settlement Risk Sharing Revenue	-	-	-	-	-	-
10.	Aggregate Write-Ins for Other Revenues	-	-	-	-	-	-
11.	TOTAL REVENUE (Items 1 to 10)	-	-	-	-	-	-
Medical and Hospital							
12.	Inpatient Services - Capitated	-	-	-	-	-	-
13.	Inpatient Services - Per Diem	-	-	-	-	-	-
14.	Inpatient Services - Fee-For-Service/Case Rate	-	-	-	-	-	-
15.	Primary Professional Services - Capitated	-	-	-	-	-	-
16.	Primary Professional Services - Non-Capitated	-	-	-	-	-	-
17.	Other Medical Professional Services - Capitated	-	-	-	-	-	-
18.	Other Medical Professional Services - Non-Capitated	-	-	-	-	-	-
19.	Non-Contracted Emergency Room and Out-of-Area Expense, not including POS	-	-	-	-	-	-
20.	POS Out-Of-Network Expense	-	-	-	-	-	-
21.	Pharmacy Expense - Capitated	-	-	-	-	-	-
22.	Pharmacy Expense - Fee-for-Service	-	-	-	-	-	-
23.	Aggregate Write-Ins for Other Capitated Medical and Hospital Expenses	-	-	-	-	-	-
24.	Aggregate Write-Ins for Other Non-Capitated Medical and Hospital Expenses	-	-	-	-	-	-
25.	TOTAL MEDICAL AND HOSPITAL (Items 12 to 24)	-	-	-	-	-	-
Administration							
26.	Compensation	-	-	-	-	-	-
27.	Interest Expense	-	-	-	-	-	-
28.	Occupancy, Depreciation and Amortization	-	-	-	-	-	-
29.	Management Fees	-	-	-	-	-	-
30.	Marketing	-	-	-	-	-	-
31.	Affiliate Administration Services	-	-	-	-	-	-
32.	Aggregate Write-Ins for Other Administration	-	-	-	-	-	-
33.	TOTAL ADMINISTRATION (Items 26 to 32)	-	-	-	-	-	-
34.	TOTAL EXPENSES	-	-	-	-	-	-
35.	INCOME (LOSS)	-	-	-	-	-	-
36.	Extraordinary Item	-	-	-	-	-	-
37.	Provision for Taxes	-	-	-	-	-	-
38.	NET INCOME (LOSS)	-	-	-	-	-	-

Deliverable Templates

2. Provider Monitoring Report (Exhibit A5, Provision 11, Sub provision 4)

Provider Monitoring Report					
Plan Name:			**Reporting Year:**		
Provider Monitoring Report		**Provider Monitoring Report**		**Provider Monitoring Report**	
Provider:		**Provider:**		**Provider:**	
Provider NPI:		**Provider NPI:**		**Provider NPI:**	
Dental Plan Name:		**Dental Plan Name:**		**Dental Plan Name:**	
Reviewed by:		**Reviewed by:**		**Reviewed by:**	
Service Site Audit Findings:		Service Site Audit Findings:		Service Site Audit Findings:	
Overall Results:		Overall Results:		Overall Results:	
*"No structural deficiencies identified" (if no findings)		*"No structural deficiencies identified" (if no findings)		*"No structural deficiencies identified" (if no findings)	
*(Provide reason for audit finding - if applicable)		*(Provide reason for audit finding - if applicable)		*(Provide reason for audit finding - if applicable)	
Dental Record (Chart) Audit Findings:		Dental Record (Chart) Audit Findings:		Dental Record (Chart) Audit Findings:	
Overall Results:		Overall Results:		Overall Results:	
*"No structural deficiencies identified" (if no findings)		*"No structural deficiencies identified" (if no findings)		*"No structural deficiencies identified" (if no findings)	
*(Provide reason for audit finding)		*(Provide reason for audit finding)		*(Provide reason for audit finding)	
*(Provide reason for audit finding)		*(Provide reason for audit finding)		*(Provide reason for audit finding)	
Utilization Review of Encounter Data:		Utilization Review of Encounter Data:		Utilization Review of Encounter Data:	
Overall Results:		Overall Results:		Overall Results:	
Corrective Action Plan: (provide reasoning for Correction Action Plan)		**Corrective Action Plan:** (provide reasoning for Correction Action Plan)		**Corrective Action Plan:** (provide reasoning for Correction Action Plan)	

Deliverable Templates

3. Timely Access and Specialty Referral Report, & Out-of-Network Referral (Exhibit A11, Provision 2, Sub provision 2.5)

Timely Access, Specialty Referral & Out-of-Network Referral Report		Report Due Dat	Submission D	Reporting Year	Reporting Quarter
DMC Plan Name					
	Age group	Age 0-20	Age 21+	All Ages	Notes/Comments
Member Information	Total Enrollee Count Month 1				
	Total Enrollee Count Month 2				
	Total Enrollee Count Month 3				
Network Capacity and Provider to Member Ratios	Total number of Primary Care Dentists				
	Total number of Network Dentists				
	Ratio of Primary Care Dentists to Members				
	Ratio of Network Dentist to Members				
TIMELY ACCESS REPORT	% of Initial Appointments offered within 4 weeks				
	Number of offices surveyed that indicated appointments available within 4 weeks				
	Number of offices surveyed				
	Average number of days to initial appointment				
	% of Routine Appointments offered within 4 weeks				
	Number of offices surveyed that indicated appointments available within 4 weeks				
	Number of offices surveyed				
	Average number of days to routine appointment				
	% of Preventive Appointments offered within 4 weeks				
	Number of offices surveyed that indicated appointments available within 4 weeks				
	Number of offices surveyed				
	Average number of days to Preventive appointment				
	% of Emergency Appointments offered within 24 hours				
	Number of offices surveyed that indicated appointments available within 24 hours				
	Number of offices surveyed				
	Average number of hours to emergency appointment				
	% of Children's Specialist Appointments offered within 30 Calendar days				
	Number of offices surveyed that indicated appointments available within 30 Calendar days				
	Number of offices surveyed				
	Average number of calendar days to schedule appointment				
	% of Adult's Specialist Appointments offered within 30 Business days				
	Number of offices surveyed that indicated Adult Specialist appointments available within 30 Business days				
	Number of offices surveyed				
	Average number of business days to schedule appointment				
	% All Appointments				
	Average % of No Show Appointments				
	% of Provider locations with available Interpreter Services				
	% of Provider locations with available Answering Services				
	Total # of Members who are assigned to a PCD that is more than 30 minutes or 10 miles from their residence				
	# of Routine Authorization Requests Received				
	% of Routine Authorizations Approved within 5 business days				
	% of Routine Authorizations Approved within 10 business days				
	% of Routine Authorizations Approved outside of 10 business days				
Specialty Referrals	# of Specialty Referral Requests Received				
	# of Members Referred to a Specialist				
	# of Members Seen by a Specialist within 30 Calendar days				
	# of Members Seen by a Specialist within 60 Calendar days				
	# of Referrals Expired without Member being Seen				
Out-of-Network (OON) Referrals	# of Members Referred to a OON Provider				
	# of OON Referral Requests Received				
	# of Members Referred to a OON Primary Care Dentist				
	# of Members Referred to a OON Specialty (Within the comments box, please indicate the type of OON Specialty provider members were referred to and number of members referred per				
	# of Members Referred to a OON FQHC				
	# of Members Referred to a OON RHC				
	# of Members Referred to a OON IHCP				
	# of Members Seen by an OON Provider within 30 Calendar days				
	# of Members Seen by an OON Provider within 60 Calendar days				
	# of Referrals Expired without Member being Seen				

Deliverable Templates

4. Call Center Report (Exhibit A14, Provision 3)

Reporting Year:							
Quarter 1 GMC							
Type of Calls	Questions on Benefits	Provider Information	Access to Services	Grievance	Health Education	Specialty Referrals	Other (Please specify)
Number of Calls							

Average Speed of Answering Calls	
Calls Abandonment Rate	
"P" Factor*	

Quarter 1 PHP							
Type of Calls	Questions on Benefits	Provider Information	Access to Services	Grievance	Health Education	Specialty Referrals	Other (Please specify)
Number of Calls							

Average Speed of Answering Calls	
Calls Abandonment Rate	
"P" Factor*	

5. Plan Provider Network Report (Exhibit A8, Provision 9)

Type	Last	First	NPI	License #	Taxonomy Code	Classification	Specialization	Office Name	Address	City	State	Zip	Phone Number	Email	Total Members Assigned	Members Under Age 21	Members Age 21 and Older	New Members (Y/N)	Accepting New Members	Provider Since	Term Date

6. Changes to Plan Provider Network Report (Exhibit A8, Provision 8)

Type	Addition or Deletion (A/D)	Last	First	NPI	License #	Taxonomy Code	Classification	Specialization	Office Name	Address	City	State	Zip	Phone Number	Email	Total Members Assigned	Members Under Age 21	Members Age 21 and Older	Accepting New Members (Y/N)	Date Accepting New Members Last Updated	Provider Since	Provider Cancellation Date	Members moved to alternate provider at same location? (Y/N)	If 'N', input office location members reassigned	Members Moved to Office Address	Members Moved to Office City	Members Moved to Office State	Members Moved to Office Zip

Deliverable Templates

7. Corrective Action Plan (Exhibit A5, Provision 13)

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:	**Management Approval:**
MDSD Denied:	
Reviewed By:	

MDSD Comments:

Deliverable Templates

8. Distance Standard (Exhibit A1, Provision 3, Subprovision 4)

Time and Distance							
Plan Name:			**Reporting Year:**				
Sacramento GMC Child							
	Standard	**Goal**	**Q1**	**Q2**	**Q3**	**Q4**	**Annual**
Enrollees with Access	1 in 10 miles or 30 mins	100%					
Enrollees without Access							
Percent with Access							
Sacramento GMC Child							
	Benchmark	**Goal**	**Q1**	**Q2**	**Q3**	**Q4**	**Annual**
Enrollees with Access	1 in 10 miles or 30 mins	100%					
Enrollees without Access							
Percent with Access							
Los Angeles PHP Adult							
	Benchmark	**Goal**	**Q1**	**Q2**	**Q3**	**Q4**	**Annual**
Enrollees with Access	1 in 10 miles or 30 mins	100%					
Enrollees without Access							
Percent with Access							
Los Angeles PHP Child							
	Benchmark	**Goal**	**Q1**	**Q2**	**Q3**	**Q4**	**Annual**
Enrollees with Access	1 in 10 miles or 30 mins	100%					
Enrollees without Access							
Percent with Access							

EXHIBIT B: BUDGET DETAIL & PAYMENT PROVISIONS

1. BUDGET CONTINGENCY CLAUSE

Any requirement of payment or performance by DHCS and Contractor for the period of the Contract will be dependent upon the availability of future appropriations by the Legislature for the purpose of the Medi- Cal program.

1. It is mutually agreed that if the appropriation provided in the enacted budget for the State of California for any years covered under this Contract does not appropriate sufficient funds for the program, DHCS shall have no liability to pay any funds whatsoever to Contractor or to furnish any other considerations under this Contract, and Contractor shall not be obligated to perform any provisions of this Contract in any year when insufficient funding may occur. Further, should funding for any Fiscal Year be reduced or deleted by the Budget Act for purposes of this program, DHCS shall have the option to:

    a. Cancel this Contract with no liability accruing to DHCS and no further obligation by Contractor to perform hereunder; or

    b. Offer a Contract amendment to Contractor to reflect the reduced amount of available funding.

2. All payments are subject to the availability of federal appropriation of Medicaid funding.

2. CONTRACTOR RISK

Except as otherwise specified in this Contract, Contractor will assume the total risk of providing Covered Services to Members on the basis of periodic Capitation Payments paid to Contractor by DHCS for each Member. Subject to SECTION 13. MEDICAL LOSS RATIO (MLR) REMITTANCE, any funds not expended by Contractor after having fulfilled all obligations under this Contract may be retained by Contractor.

3. CAPITATION PAYMENT RATES

1. DHCS shall remit to Contractor a Capitation Payment no later than 45 calendar days after the first day of each month for each Member that appears on the approved list of Members supplied to Contractor by DHCS. The payment period shall commence on the first day of the Operations Period. Capitation Payments shall be made in accordance with the schedule of Capitation Payment rates set forth below. For the list of aid codes included in each Rate

Group below, please see the definition of Potential Member set forth in EXHIBIT E1: DEFINITIONS of this Contract.

Rate Groups	**Rates**
For the period July 01, 2025 – December 31, 2025	**Sacramento**
Child SIS	$
Adult SIS	$
Adult Expansion SIS	$
For the period July 01, 2025 – December 31, 2025	**Los Angeles**
Child SIS	$
Adult SIS	$
Adult Expansion SIS	$

2. 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 Contract Revenue effect for Contractor, then the split aid code will automatically be included in the same Rate Group as the original aid code covered under this Contract. Contractor agrees to accept the Capitation Payment rate specified for the original aid code as payment in full for members in the new aid code. DHCS shall confirm all aid code splits and the rates of payment for such new aid codes in writing to Contractor as soon as practicable after such aid code splits occur.

3. In accordance with 42 Code of Federal Regulations (CFR), part 438, section 438.7, the actuarial basis for the computation of Capitation Payment rates shall be set forth in DHCS' rate certification(s) for the applicable Rating Period. Subject to approval by CMS, said rate certification(s) are hereby incorporated by reference and made a part of this Contract by this reference as if attached hereto in full.
4. Payment Withhold

   DHCS will withhold six (6) percent of the monthly capitation payment in accordance with 42 CFR, Part 438.6(b)(3), 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: Performance Measures (3 percent) and Deliverables (3 percent).

a. Payment of Withheld Funds

i. Performance Measures: Payment of the three (3) percent 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 and quality metrics during the measurement year. DHCS will evaluate the Contractor's performance on an annual basis which shall commence no sooner than 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. The percentage of the retained amount payable to the Contractor will be determined by the performance withhold percentage table. (See SECTION 2. PERFORMANCE MEASURES AND QUALITY METRICS) Upon completion of the performance evaluation, DHCS will notify plans in writing within ten (10) business days of the evaluation results.

ii. Deliverables: Payment of the three (3) percent 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 A18: DELIVERABLE SCHEDULE. At the end of the measurement year, DHCS will determine the amount of the three (3) percent withhold that is payable to the Contractor, and notify plans in writing of the release within ten (10) business days.

b. Determination of Performance

i. Performance Measures: Payment of the three (3) percent performance measures and quality metrics withhold of the Contractor's capitation shall be contingent upon meeting or exceeding the annual established benchmarks for specific performance measures and quality metrics. Each performance measure will be allocated an annual benchmark. The Contractor must meet or exceed the benchmark to be awarded the three (3) percent of performance measures and quality metrics withhold as indicated in the performance withhold percentage table. (See EXHIBIT A6: PERFORMANCE MEASURES AND BENCHMARKS).

The Contractor's performance will be evaluated on an annual basis which shall commence no sooner than 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.

c. Failure to Perform

i. 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.

DHCS will notify Contractor in writing if the Contractor is at risk of not meeting a specific obligation.

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.

DHCS will work closely with Contractor to monitor and assist Contractor in meeting all requirements.

ii. If Contractor is not able to meet or exceed Contract performance requirements, Sub provision 4, Paragraph (a), Payment of Withheld Funds, will apply.

iii. DHCS shall have sole discretion in approving any standard or deliverable that is deemed in compliance and considered timely.

iv. In the event Contractor is consistently not able to meet the performance measures, DHCS reserves the right to sanction the Contractor in accordance with the Sanctions provision within this Contract and any subsequent DHCS issued APLs.

d. 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 that does not meet the standard described in Paragraph (e), Verification Reviews, will not be reimbursed to Contractor.

e. Verification Review

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.

4. CAPITATION PAYMENT RATES CONSTITUTE PAYMENT IN FULL

Except as otherwise specified in this Contract, Capitation Payment rates for each Rating Period, as calculated by DHCS and approved by CMS, are prospective rates and constitute payment in full on behalf of a Member for all Covered Services required by such Member and for all Administrative Costs incurred by Contractor in providing or arranging for such services under the terms of this Contract. Except as otherwise specified in this Contract, DHCS is not responsible for making payments associated with Contractor's losses.

5. DETERMINATION AND REDETERMINATION OF CAPITATION PAYMENT RATES

1. In accordance with Welfare and Institutions Code (W&I) section 14301.1, DHCS shall establish Capitation Payment rates on an actuarial basis for each Rating Period, and reserves the right to redetermine and to amend such rates as necessary and appropriate.

    a. DHCS shall establish Capitation Payment rates in accordance with Welfare and Institutions Code (W&I) section 14301.1, applicable federal and State laws and regulations, and generally accepted actuarial principles and practices.

    b. DHCS reserves the right, subject to actuarial judgment and generally accepted actuarial principles and practices, to consider Contractor's performance on specified quality and access benchmarks, as determined by DHCS and communicated to MCPs in advance of each applicable Rating Period, within the determination of Capitation Payment rates for that Rating Period.

    c. If Contractor delegates financial risk for the provision of Covered Services in accordance with SECTION 15. FINANCIAL VIABILITY OF SUBCONTRACTORS AND NETWORK PROVIDERS, DHCS reserves the right, subject to actuarial

judgment and generally accepted actuarial principles and practices, to consider the actual payments received by Providers for providing Covered Services to Members to inform the determination of Capitation Payment rates.

2. Capitation Payment rates shall be effectuated through an amendment or change order to this Contract in accordance with SECTION 2. AMENDMENT AND CHANGE ORDER PROCESS subject to the following provisions:

    a. The amendment/change order shall be effective as of the first day of the Rating Period of each Rating Period covered by this Contract.

    b. In the event there is any delay in a determination or redetermination of Capitation Payment rates, so that an amendment or change order may not be processed in time to permit payment of new rates commencing the first day of the Rating Period, payment to Contractor shall continue at the rates stated in an R Letter sent to Contractor by DHCS. The R Letter shall serve as notification from DHCS to Contractor of the capitated rates, and the time period for which these rates will be applied. The R Letter shall not be considered exempt from any requirement of this Contract. Those continued payments shall constitute interim payment only. Upon CMS final approval of the amendment or change order and rate certification(s), 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 Capitation Payment rates prior to full approval by CMS of the amendment or change order to this Contract implementing such new rates, Contractor stipulates to a confession of judgment for any and all amounts received in excess of the final approved rate. In the event that the final approved rate differs from the rates established by DHCS or agreed upon by Contractor and DHCS:

        i. Any underpayment by DHCS shall be paid to Contractor after final approval of the new rates. DHCS will provide Contractor a timeframe for payment of any underpayments;

        ii. Unless otherwise required by CMS, any overpayment to Contractor shall be offset by DHCS' withholding from Contractor's future Contract Revenues of any amount due. DHCS may, at its sole discretion, withhold up to 100 percent of Contract Revenues for each month until any overpayment is fully

recovered by the State; and

iii. Contractor must review all Contract Revenues and notify DHCS of any payment errors in a form and manner specified by DHCS. If the error favors DHCS, DHCS may offset against future Contract Revenues as stated in paragraph (b) above. If the error favors Contractor, Contractor must notify DHCS within 365 calendar days of payment, otherwise Contractor forfeits the right to receive the corrected payment, except when Contractor demonstrates to DHCS' satisfaction, in a form and manner specified by DHCS, that Contractor could not reasonably have identified the error.

d. If mutual agreement between DHCS and Contractor cannot be attained on Capitation Payment rates in accordance with this Paragraph B, Contractor shall have the right to terminate this Contract. Contractor's notification of the intent to terminate this Contract must be in writing and provided to DHCS at least nine months prior to the effective date of termination, subject to any earlier termination date negotiated in accordance with the terms set forth in SECTION 3. TERMINATION of this Contract. DHCS shall pay Capitation Payment rates determined for the applicable Rating Periods until the Contract is terminated; and

e. DHCS shall make reasonable efforts to notify and consult with Contractor regarding any proposed redetermination of Capitation Payment rates in accordance with this Provision or Section F below prior to implementation of any new rates.

6. REDETERMINATION OF CAPITATION PAYMENT RATES DUE TO OBLIGATION CHANGES

Final Capitation Payment rates may be adjusted during or subsequent to the applicable Rating Period to provide for changes in obligations that result in a material projected increase or decrease of cost as determined by the certifying actuaries, in accordance with W&I Code section 14301.1, to Contractor. Any adjustments shall be effectuated through an amendment or change order to the Contract subject to the following:

1. The amendment or change order shall be effective as of the first day of the month in which the change in obligations is effective, as determined by DHCS;

2. In accordance with Subsection 5.2.B of this Exhibit, in the event DHCS is unable to process the amendment or change order in sufficient 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. Upon final approval of the amendment or change order, DHCS shall make adjustments for those months in which interim payments were made; and

3. DHCS and Contractor may negotiate an earlier termination date, pursuant to SECTION 3.3. TERMINATION WITHOUT CAUSE - CONTRACTOR, of this Contract, in the event a change in contractual obligations is created by a State or federal change in the Medi-Cal program, or by 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 through the termination date provided by this Contract.

7. RECOVERY OF AMOUNTS PAID TO CONTRACTOR

DHCS shall have the right to recover from Contractor amounts paid to Contractor in the following circumstances:

1. If DHCS determines that a Member has been improperly enrolled due to ineligibility of the Member to enroll in Contractor's Dental Managed Care Health Plan, a Member's residence is outside of Contractor's Service Area, or, pursuant to 22 CCR Section 53891(a)(2), or a Member should have been disenrolled with an effective date in a prior month, DHCS may recover amounts paid to Contractor associated with the Member for the month(s) in question. To the extent permitted by law, 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 may be paid by the DHCS fiscal intermediary if the Member is determined eligible for the Medi-Cal program;

2. Upon request by Contractor, DHCS may allow Contractor to retain amounts paid to Contractor associated with a Member who is eligible to enroll in Contractor's Medi-Cal Dental Managed Care Health Plan, but should have been retroactively disenrolled in accordance with SECTION 4. DISENROLLMENT of this Contract or under other circumstances as approved by DHCS. If Contractor retains Capitation Payments, Supplemental Payments, and any other additional payments, Contractor shall provide or arrange and pay for all Medically Necessary Covered Services for the Member until such Member is disenrolled on a non-retroactive basis pursuant to the terms set forth in SECTION 4. DISENROLLMENT of this Contract;

3. As a result of Contractor's failure to perform contractual responsibilities to comply with

mandatory federal Medicaid requirements, the United States Department of Health and Human Services (U.S. DHHS) may disallow Federal Financial Participation for payments made by DHCS to Contractor. In this event, DHCS may recover the amounts disallowed by U.S. DHHS by imposing an offset to Contract Revenues. If recovery of the full amount at one time imposes a financial hardship on Contractor, Contractor may request to repay the recoverable amounts in monthly installments over a period of consecutive months not to exceed six months. DHCS, at its sole discretion, may grant or deny such a request; and

4. If DHCS determines that any other erroneous or improper payment(s) not mentioned above has been made to Contractor, DHCS may recover all such determined amounts by the imposition of an offset to Contract Revenues. At least 30 calendar days prior to seeking any such recovery, DHCS shall notify Contractor of the improper or erroneous nature of the payment and shall describe the recovery process. If recovery of the full amount at one time imposes a financial hardship on Contractor, Contractor may request to repay the recoverable amounts in monthly installments over a period of consecutive months not to exceed six months. DHCS, at its sole discretion, may grant or deny such a request.

8. REINSURANCE

In accordance with 22 CCR Section 53252, Contractor may obtain reinsurance (i.e., stop loss coverage) to ensure maintenance of adequate capital by Contractor for the cost of providing Covered Services under this Contract, subject to the following conditions:

1. Reinsurance shall not reduce Contractor's liability below $5,000 per Member for any one 12-month period.

2. Reinsurance may cover both of the following:

    a. The total cost of services provided to Members under emergency circumstances by non- contracted Providers, including the cost of Medi-Cal inpatient care in a non-contracted facility until such time as the Member may be safely transported to a Network facility; and

    b. Up to 90 percent of all expenditures related to this Contract exceeding 115 percent of Contract Revenues and third-party recoveries during any Fiscal Year of Contractor.

3. At its sole discretion and determination, and following consultation with Contractor, DHCS may require Contractor to retain appropriate reinsurance coverage for high-cost Members or services.

9. CATASTROPHIC COVERAGE LIMITATION

DHCS may limit Contractor's liability to provide or arrange and pay for health care services for illness of, or injury to Members, resulting from or greatly aggravated by a catastrophic occurrence or disaster which occurs subsequent to Enrollment. Following the Director's invocation of this Catastrophic Coverage Limitation, Contractor will return a prorated amount of the total Capitation Payment received by Contractor for the month. The amount returned will be determined by dividing the total Capitation Payment made to Contractor for such month by the number of days in that month, whereupon Contractor will return the amount to DHCS for each day in of the month after the Director’s invocation of this Catastrophic Coverage Limitation provision.

10. FINANCIAL PERFORMANCE GUARANTEE

In accordance with Title 22 CCR Section 53865, Contractor must annually provide satisfactory evidence of, and maintain a Financial Performance Guarantee in the form specified by DHCS and in an amount at least one million dollars or equal to at least one (1) month’s Contract Revenues based on Contractor’s average monthly Contract Revenues for last 12 months, whichever is higher, subject to approval by DHCS. At Contractor's request, and with DHCS approval, Contractor may establish a phase-in schedule to accumulate the required Financial Performance Guarantee. Unless DHCS has a financial claim or offset against Contractor, the Financial Performance Guarantee shall remain in effect through the completion of the phaseout period in accordance with SECTION 3. TERMINATION, SECTION 14. CONTRACT TERM, and SECTION 17. PHASEOUT REQUIREMENTS of this Contract. DHCS shall take possession of the Financial Performance Guarantee in an amount sufficient to indemnify DHCS in the event that Contractor materially breaches or defaults on one or more terms this Contract.

11. MEDICARE COORDINATION

In accordance with 42 CFR section 438.3(t), Contractor shall enter into a Coordination of Benefits Agreement with the Medicare program through CMS, and shall agree to participate in Medicare’s automated claims crossover process for full benefit dual eligible Members.

12. SPECIAL CONTRACT PROVISIONS RELATED TO PAYMENT

1. Contractor must reimburse Providers pursuant to the terms of each applicable Directed Payment Initiative in accordance with 42 CFR section 438.6(c) in a form and manner

specified by DHCS through APLs or other technical guidance. For applicable Rating Periods, DHCS shall make the terms of each approved Directed Payment Initiative available on the DHCS website. The Directed Payment Initiatives in effect are:

a. Proposition 56 Directed Payments for Dental Services, which requires Contractor to pay eligible Network Providers enhanced contracted payments that are uniformly adjusted by specified amounts or percentages based on the type of procedure in accordance with the CMS approved directed payment preprints, located at https://www.dhcs.ca.gov/services/ Pages/DP-Dental.aspx, and APL 22-012, "Continued Supplemental Payment For Certain Dental Services Using Proposition 56 Tobacco Tax Funds", located at https://www.dhcs.ca.gov/services/Documents/APL-22-012-Prop-56.pdf.

b. CalAIM Directed Payments for Preventative Dental Care Services, which requires Contractor to pay eligible Network Providers 75% above the Schedule of Maximum Allowance for various dental preventive service codes, in accordance with APL 21-005, "CalAIM Implementation Requirements," located at https://www.dhcs.ca.gov/provgovpart/ denti-cal/Documents/APL-21-005-CalAIM-Requirements-and-Enclosure.pdf, and Welfare and Institutions Code §14184.500.

2. Contractor must comply with the terms of any Incentive Arrangements approved by CMS under 42 CFR section 438.6(b)(2), in a form and manner specified by DHCS through All Plan Letters or other technical guidance. For applicable Rating Periods, DHCS will make the terms of each approved Incentive Arrangement available on the DHCS website.

3. Contractor must comply with the terms of any Risk Sharing Mechanisms instituted in accordance with 42 CFR section 438.6(b)(1), in a form and manner specified by DHCS through All Plan Letters or other technical guidance. For applicable Rating Periods, DHCS will make the terms of each approved Risk Sharing Mechanism available on the DHCS website.

13. MEDICAL LOSS RATIO (MLR) REMITTANCE

Contractor must provide a remittance to DHCS for an MLR reporting year if the MLR reported in accordance with SECTION 5. MEDICAL LOSS RATIO (MLR) for that MLR reporting year does not meet a minimum MLR standard of 85 percent. DHCS shall validate Contractor's reported remittance amount pursuant to SECTION 5. MEDICAL LOSS RATIO (MLR) and determine the final remittance amount owed by Contractor for each MLR reporting year and rating region. Starting January 1, 2025,

Contractor must impose equivalent remittance requirements on its Fully Delegated Subcontractors, Partially Delegated Subcontractors, Downstream Fully Delegated Subcontractors, and Downstream Partially Delegated Subcontractors.

14. STATE PROGRAM RECEIVING FEDERAL FINANCIAL PARTICIPATION

Should any part of the scope of work under this Contract relate to a State program receiving Federal Financial Participation (FFP) that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), Contractor must do no work on that part no longer authorized by law after the effective date of the loss of such program authority. DHCS must adjust Capitation Payments to remove costs that are specific to any State program or activity receiving FFP that is no longer authorized by law to receive FFP. If Contractor works on a State program or activity receiving FFP that is no longer authorized by law after the date the legal authority for the work ends, Contractor will not be paid for that work. If DHCS has paid Contractor in advance to work on a no-longer-authorized State program or activity receiving FFP and under the terms of this contract the work was to be performed after the date the legal authority ended, the payment for that work should be returned to DHCS. However, if Contractor worked on a State program or activity receiving FFP prior to the date legal authority ended for that State program or activity receiving FFP, and DHCS included the cost of performing that work in its payments to Contractor, Contractor may keep the payment for that work even if the payment was made after the date the State program or activity receiving FFP lost legal authority.

EXHIBIT C: GENERAL TERMS AND CONDITIONS

GENERAL TERMS AND CONDITIONS

The State's General Terms and Conditions (GTC 02/2025) can only be viewed or downloaded from the following link:

https://www.dgs.ca.gov/OLS/Resources/Page-Content/Office-of-Legal-Services-Resources-List-Folder/ Standard-Contract-Language

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 proposing firm does not have Internet access they are to contact the program identified in the response cover letter to request a hard or paper copy of the State's General Term and Conditions.

Exhibit D
Special Terms and Conditions

The provisions herein apply to this Agreement **unless** the applicable conditions do not exist, the provisions are superseded by an alternate provision appearing elsewhere in this Agreement, or the provisions are removed by reference on the face of this Agreement.

The use of headings or titles throughout this exhibit is for convenience only and will not be used to interpret or to govern the meaning of any specific term or condition.

The terms "contract", "Contractor" and "Subcontractor" will 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” will 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.).

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 will 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, Section503 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 will 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 will 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 Code of Federal Regulations (C.F.R.) 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 C.F.R. Part 60, "Office of 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 canceled, 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 C.F.R. Part 60, "Office of 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 C.F.R. Part 60, "Office of 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 will, unless otherwise specified in this Agreement, be at the rates currently in effect, as established by the California Department of Human Resources (CalHR), for non-represented state employees as stipulated in DHCS' Travel Reimbursement Information Exhibit. If the CalHR rates change during the term of the Agreement, the new rates will apply upon their effective date and no amendment to this Agreement will be necessary. Exceptions to CalHR 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 will 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 will 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 will 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 must not exceed $50,000 annually.

   To secure equipment/property above the annual maximum limit of $50,000, the Contractor must 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 will be deducted from the funds available in this Agreement. Contractor will 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 will also apply, if equipment/property purchases are delegated to subcontractors that are either a government or public entity.

3) Nonprofit organizations and commercial businesses must use a procurement system that meets the following standards:

   a) Maintain a code or standard of conduct that will govern the performance of its officers, employees, or agents engaged in awarding procurement contracts. No employee, officer, or agent will 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 must be conducted in a manner that provides, to the maximum extent practical, open, and free competition.

   c) Procurements must be conducted in a manner that provides for all of the following:

      i. Avoid purchasing unnecessary or duplicate items.

      ii. Equipment/property solicitations must be based upon a clear and accurate description of the technical requirements of the goods to be procured.

      iii. 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) must 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 will 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 will 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 must report the receipt to the DHCS Program Contract Manager. To report the receipt of said items and to receive property tags, Contractor must 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 must 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 must 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 must request a copy from the DHCS Program Contract Manager. Contractor must:

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 will not be affected by its incorporation or attachment to any property not owned by the State.

c. Unless otherwise stipulated, DHCS will 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 must 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 must immediately file a theft report with the appropriate police agency or the California Highway Patrol and Contractor must 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, must 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 must provide a final inventory report of equipment and/or property to the DHCS Program Contract Manager and must, 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 will be at DHCS expense and according to DHCS instructions. Equipment and/or property disposition instructions will 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 must return such vehicles to DHCS and must 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 will be the legal owner of said motor vehicles and the Contractor will 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, must 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 must 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, must 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 must, as soon as practical, furnish a copy of the certificate of insurance to the DHCS Program Contract Manager. The certificate of insurance must 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, will 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:

   I. 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).

   II. 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 any extension or continuation of this Agreement.

   III. The insurance carrier must 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 will 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 will 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 will 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 must 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 desirability of 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 federal government,

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 Volume 1 Chapter 5 Section 5.80 Subsection B.

i) Entities whose name and budgeted costs have been submitted to DHCS in response to a competitive Invitation for Bid or Request for Proposal.

b. Agreements with governmental or public entities and their auxiliaries, or a Joint Powers Authority

1) If the total amount of all subcontracts exceeds twenty-five percent (25%) of the total agreement amount or $50,000, whichever is less and each subcontract is not with an entity or of a service type described in paragraph a(3) herein, DHCS will:

a) Obtain approval from DGS to use said subcontracts, or

b) If applicable, obtain a certification from the prime Contractor indicating that each subcontractor was selected pursuant to a competitive bidding process requiring at least three bids from responsible bidders, or

c) Obtain attestation from the Secretary of the California Health and Human Services Agency attesting that the selection of the particular subcontractor(s) without competitive bidding was necessary to promote DHCS' program needs and was not done for the purpose of circumventing competitive bidding requirements.

2) When the conditions of b(1) apply, each subcontract that is not with a type of entity or of a service type described in paragraph a(3) herein, must not commence work before DHCS has obtained applicable prior approval to use said subcontractor. DHCS will inform the Contractor when DHCS has obtained appropriate approval to use said subcontractors.

c. 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 must 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.

2) The requirements specified in Provision 28 entitled, "Use of Disabled Veteran Business Enterprises (DVBEs)" will apply to the use and substitution of DVBE subcontractors.

3) The requirements specified in Provision 30 entitled, "Use of Small Business Subcontractors" will apply to the use and substitution of small business subcontractors.

d. 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 must be confirmed in writing by DHCS.

e. Contractor must maintain a copy of each subcontract entered into in support of this Agreement and must, upon request by DHCS, make copies available for approval, inspection, or audit.

f. 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.

g. The Contractor is responsible for all performance requirements under this Agreement even though performance may be carried out through a subcontract.

h. When entering into a consulting agreement with DHCS, the contract must include detailed criteria and a mandatory progress schedule for the performance of the contract, and must require Contractor to provide a detailed analysis of the costs of performing the contract.

i. The Contractor must ensure that all subcontracts for services include provision(s) requiring compliance with applicable terms and conditions specified in this Agreement.

j. 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."

k. Unless otherwise stipulated in writing by DHCS, the Contractor will be the subcontractor's sole point of contact for all matters related to performance and payment under this Agreement.

l. Contractor must, 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, 18, 19, 20, 32, 37, 38 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 must 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 must 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 must be subject at all reasonable times to inspection, audit, and reproduction.

c. Contractor agrees that DHCS, DGS, the California State Auditor, or their designated representatives including, but not limited to, the Comptroller General of the United States will 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. (Government Code (Gov. Code) § 8546.7, Title 2 Code of California Regulations (C.C.R.), § 1896.77 and other applicable State laws.) The Contractor must comply with the above and be aware of the penalties for violations of fraud and for obstruction of an investigation under applicable State laws.

d. The Contractor and/or Subcontractor must preserve and make available his/her records (1) for a period of six years for all records related to Disabled Veteran Business Enterprise (DVBE) participation (Military and Veterans Code (Mil. & Vet. Code) § 999.55), if this Agreement involves DVBE participation, and three years for all other contract records 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 must be preserved and made available for a period of three 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-year period, the records must be retained until completion of the action and resolution of all issues which arise from it, or until the end of the regular three-year period, whichever is later.

e. 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.

f. For agreements with non-profit entities funded in part or whole with federal funds in the amount of $750,000 or more, the Contractor must, if applicable, comply with the Single Audit Act and the audit requirements set forth in 2 C.F.R. § 200.501 et seq.

g. For Direct Service Contracts as defined in Health & Saf. Code § 38040 in the amount of $25,000 or more, the Contract must comply with the audit requirements set forth in Health & Saf. Code § 38040.

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 must provide and must 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 will 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. Termination

a. **For Cause**

The State may terminate this Agreement, in whole or in part, and be relieved of any payments should the Contractor fail to perform the requirements of this Agreement at the time and in the manner herein provided. In the event of such termination, the State may proceed with the work in any manner deemed proper by the State. All costs to the State will be deducted from any sum due the Contractor under this Agreement and the balance, if any, will be paid to the Contractor upon demand. If this Agreement is terminated, in whole or in part, the State may require the Contractor to transfer title, or in the case of licensed software, license, and deliver to the State any completed deliverables, partially completed deliverables, and any other materials, related to the terminated portion of the Contract, including but not limited to, computer programs, data files, user and operations manuals, system and program documentation, training programs related to the operation and maintenance of the system, and all information necessary for the reimbursement of any outstanding Medicaid claims. The State will pay contract price for completed deliverables delivered and accepted and items the State requires the Contractor to transfer as described in this paragraph above.

b. **For Convenience**

The State retains the option to terminate this Agreement, in whole or in part, without cause, at the State's convenience, without penalty, provided that written notice has been delivered to the Contractor at least thirty (30) calendar days prior to such termination date. In the event of termination, in whole or in part, under this paragraph, the State may require the Contractor to transfer title, or in the case of licensed software, license, and deliver to the State any completed deliverables, partially completed deliverables, and any other materials related to the terminated portion of the Contract including but not limited to, computer programs, data files, user and operations manuals, system and program documentation, training programs related to the operation and maintenance of the system, and all information necessary for the reimbursement of any outstanding Medicaid claims. The Contractor will be entitled to compensation upon submission of an invoice and proper proof of claim for the services and products satisfactorily rendered, subject to all payment provisions of the Agreement. Payment is limited to expenses necessarily incurred pursuant to this Agreement up to the date of termination.

11. Intellectual Property Rights

(Applicable to all agreements that may be fund, in whole or part, the creation and development Intellectual Property.)

a. The State will be the owner of all rights, title, and interest in any and all intellectual property or other products or materials created or developed pursuant to this Agreement, whether or not published, produced, manufactured or distributed. The copyright, patent and/or other intellectual property rights to any and all products created, provided or developed, in whole or part, under this Agreement, whether or not published, produced, manufactured or distributed belongs to the State from the moment of creation.

b. The State retains all rights to use, reproduce, distribute, or display any products or materials created, provided, developed, or produced under this Agreement and any derivative products based on Agreement products or materials, as well as all other rights, privileges, and remedies granted or reserved to a copyright, patent, service mark or trademark owner under statutory and common law.

c. Contractor agrees to cooperate with State and to execute any document(s) that may be necessary to give the foregoing provisions full force and effect, including but not limited to, an assignment of trademark, copyright or patent rights. Contractor, subject to reasonable availability, agrees to give testimony and take all further acts necessary to acquire, transfer, maintain, and enforce the State's intellectual property rights and interest.

d. Contractor agrees to cooperate with the State in assuring the State's 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 must 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 the State all rights, title and interest in Intellectual Property conceived, developed, derived from, or reduced to practice by the subcontractor, Contractor or the State and which result from this Agreement or any subcontract.

e. Contractor agrees not to incorporate into or make the works developed, dependent upon any original works of authorship or Intellectual Property Rights of third parties without first (a) obtaining State's prior written permission, and (b) granting to or obtaining for State, without additional compensation, a nonexclusive, royalty-free, paid-up, irrevocable, perpetual, world-wide license, to use, reproduce, sell, modify, publicly and privately display and distribute, for any purpose whatsoever, any such prior works.

f. Contractor will 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. **Unless otherwise specified in the Statement of Work in contracts other than those funded, in part or whole, by federal funds (see paragraph k below)**, 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. Proprietary software packages that are provided at established catalog or market prices and sold or leased to the general public will not be subject to this license provision.

g. In the case of copyrighted materials, all materials distributed under the terms of this Agreement, and any reproductions or derivative works thereof, must include a notice of copyright in a place that can be visually perceived at the direction of the State. This notice must be placed prominently on products or materials and set apart from other matter on the page or medium where it appears. The notice "Copyright" or "©", the year in which the work was first created, and the Department of Health Care Services DHCS", or other appropriate mark as directed by DHCS, must be included on any such products or materials.

h. Contractor represents and warrants that:

1) It is free to enter into and fully perform this Agreement.

2) It has secured and will secure all rights and licenses necessary for its performance of this Agreement.

3) 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 the State 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.

4) 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.

5) 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 property, sites, locations, property or props that may be used or shown.

6) It has not granted and will not grant to any person or entity any right that would or might derogate, encumber, or interfere with any of the rights granted to the State in this Agreement.

7) 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.

8) 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.

i. THE STATE 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.

j. INTELLECTUAL PROPERTY INDEMNITY

1) Contractor must indemnify, defend and hold harmless the State and its licensees and assignees, and its officers, directors, employees, agents, representatives, successors, and users of its products, ("Indemnitees") 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 the State's 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 the State and which result directly or indirectly from this Agreement. This indemnity obligation will 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. The State reserves the right to participate in and/or control, at Contractor's expense, any such infringement action brought against the State.

2) Should any Intellectual Property licensed by the Contractor to the State under this Agreement become the subject of an Intellectual Property infringement claim, Contractor will exercise its authority reasonably and in good faith to preserve the State's right to use the licensed Intellectual Property in accordance with this Agreement at no expense to the State. The State will 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 the State 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, the State will 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 the State for breach of any term of this Intellectual Property attachment by Contractor. Contractor acknowledges the State would suffer irreparable harm in the event of such breach and agrees the State will 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.

k. If this Agreement is funded in whole or part by federal funds, the State will retain all Intellectual Property rights, title, and ownership, which result directly or indirectly from the Agreement pursuant to applicable federal law including, but not limited to, 45 C.F.R. § 75.322 and 45 C.F.R. § 95.617, except as provided in 37 C.F.R. Part 401.14. However, the federal government will 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.

l. The provisions set forth herein will survive any termination or expiration of this Agreement.

12. 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 by law.

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. § 7606), Section 508 of the Clean Water Act (33 U.S.C. § 1368), Executive Order 11738, and Environmental Protection Agency regulations.

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 Clean Water Act (33 U.S.C. § 1251 et seq.), as amended.

13. Prior Approval of Training Seminars, Workshops or Conferences

Contractor must 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 must 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.

14. Confidentiality of Information

a. The Contractor and its employees, agents, or subcontractors must 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 must 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 must 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 must 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 will 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.

15. Documents, Publications and Written Reports

(Applicable to agreements over $5,000 under which publications, written reports and documents are developed or produced. Gov. Code § 7550.)

Any document, publication or written report (excluding progress reports, financial reports and normal contractual communications) prepared as a requirement of this Agreement must 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.

16. 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 must direct its grievance together with any evidence, in writing, to the program Branch Chief. The grievance must state the issues in dispute, the legal authority or other basis for the Contractor's position and the remedy sought. The Branch Chief will render a decision within ten (10) working days after receipt of the written grievance from the Contractor. The Branch Chief will 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 must 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 must 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 will 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 will be directed to the Contractor within twenty (20) working days of receipt of the Contractor's second level appeal. The decision rendered by the Deputy Director or his/her designee will be the final administrative determination by the Department.

b. Unless otherwise stipulated in writing by DHCS, all dispute, grievance and/or appeal correspondence will be directed to the DHCS Program Contract Manager.

c. 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 will 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.

e. Notwithstanding any dispute, the Contractor shall diligently continue performance of the Contract (including matters subject to dispute to the maximum extent possible).

17. Subrecipient Compliance

(Applicable to agreements in which a Subrecipient receives federal funding. This does not apply to Medi-Cal programs.)

Per 2 C.F.R. § 200.93, a Subrecipient is a non-federal entity that receives a subaward from a pass-through entity to carry out part of a federal award. Subrecipients must comply with certain requirements, including without limitation, audit requirements, as set forth in 2 C.F.R. Part 200, as applicable to Subrecipients. Subrecipients may be subject to applicable monitoring activities by DHCS as required in 2 C.F.R. § 200.332.

18. 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 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. § 263a (CLIA) and the regulations thereunder.

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 2 C.F.R. Part 180, 2 C.F.R. Part 376.

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) violation of Federal or State antitrust statutes; or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, receiving stolen property, making false claims, obstruction of justice, or the commission of any other offense indicating a lack of business integrity or business honesty that seriously affects its business honesty;

    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) Have not, within a three-year period preceding this application/proposal/agreement, engaged in any of the violations listed under 2 C.F.R. Part 180, Subpart C as supplemented by 2 C.F.R. Part 376.

6) Shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under federal regulations (i.e., 48 C.F.R .part 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State.

7) 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 must submit an explanation to the DHCS Program Contract Manager.

d. The terms and definitions herein have the meanings set out in 2 C.F.R. Part 180 as supplemented by 2 C.F.R. Part 376.

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. Drug Free Workplace Act of 1988

The Federal government implemented the Drug Free Workplace Act of 1988 in an attempt to address the problems of drug abuse on the job. It is a fact that employees who use drugs have less productivity, a lower quality of work, and a higher absenteeism, and are more likely to misappropriate funds or services. From this perspective, the drug abuser may endanger other employees, the public at large, or themselves. Damage to property, whether owned by this entity or not, could result from drug abuse on the job. All these actions might undermine public confidence in the services this entity provides. Therefore, in order to remain a responsible source for government contracts, the following guidelines have been adopted:

a. The unlawful manufacture, distribution, dispensation, possession or use of a controlled substance is prohibited in the workplace.

b. Violators may be terminated or requested to seek counseling from an approved rehabilitation service.

c. Employees must notify their employer of any conviction of a criminal drug statue no later than five days after such conviction.

d. Although alcohol is not a controlled substance, it is nonetheless a drug. It is the policy that abuse of this drug will also not be tolerated in the workplace.

e. Contractors of federal agencies are required to certify that they will provide drug-free workplaces for their employees.

22. 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 will 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.

23. 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.

24. Progress Reports or Meetings

(Applicable to consultant service agreements and, at DHCS' option, other agreements.)

a. Contractor shall submit progress reports or attend meetings with state personnel at intervals determined by DHCS to determine if the Contractor is on the right track, whether the project is on schedule, provide communication of interim findings, and afford occasions for airing difficulties or special problems encountered so that remedies can be developed quickly.

b. At the conclusion of this Agreement and if applicable, Contractor shall hold a final meeting at which Contractor shall present any findings, conclusions, and recommendations. If required by this Agreement, Contractor shall submit a comprehensive final report.

25. Performance Evaluation

a. For all consultant service agreements of $5000 or more:

   1) The Contractor's performance under this Agreement will be evaluated at the conclusion of the term of this Agreement. The evaluation will include, but not be limited to:

      a) Whether the contracted work or services were completed as specified in the Agreement and reasons for and amount of any cost overruns.

      b) Whether the contracted work or services met the quality standards specified in the Agreement.

      c) Whether the Contractor fulfilled all requirements of the Agreement and if not, in what ways the Contractor did not fulfill the contract.

      d) Factors outside the control of the Contractor, which caused difficulties in Contractor performance. Factors outside the control of the Contractor will not include a Subcontractor's poor performance.

      e) Other information the awarding agency may require.

      f) How the Contract results and findings will be utilized to meet the agency goals.

2) The evaluation of the Contractor will not be a public record.

b. For all other agreements except 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 will not be a public record and will remain on file with DHCS. Negative performance evaluations may be considered by DHCS prior to making future contract awards.

26. Officials Not to Benefit

No members of or delegate of Congress or the State Legislature will be admitted to any share or part of this Agreement, or to any benefit that may arise therefrom. This provision will not be construed to extend to this Agreement if made with a corporation for its general benefits.

27. 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.

28. Use of Disabled Veteran's Business Enterprises (DVBE)

(Applicable to agreements over $10,000 in which the Contractor committed to achieve DVBE participation. Not applicable to agreements and amendments specifically exempted from DVBE requirements by DHCS.)

a. The State Legislature has declared that a fair portion of the total purchases and contracts or subcontracts for property and services for the State be placed with disabled veteran business enterprises.

b. All DVBE participation attachments, however labeled, completed as a condition of bidding, contracting, or amending a subject agreement, are incorporated herein and made a part of this Agreement by this reference.

c. Contractor agrees to use the proposed DVBEs, as identified in previously submitted DVBE participation attachments. Contractor understands and agrees to comply with the requirements set forth in Mil. & Vet. Code § 999 et seq. in that should award of this Contract be based on part on its commitment to use the DVBE subcontractor(s) identified in its bid or offer, per Mil. & Vet. Code § 999.5(g), a DVBE subcontractor may only be replaced by another DVBE subcontractor and must be approved by both DHCS and the DGS prior to the commencement of any work by the proposed subcontractor. Changes to the scope of work that impact the DVBE subcontractor(s) identified in the bid or offer and approved DVBE substitutions will be documented by contract amendment.

d. Requests for DVBE subcontractor substitution must include:

   1) A written explanation of the reason for the DVBE substitution.

   2) A written description of the business enterprise that will be substituted, including its DVBE certification status and contact information.

   3) A written description of the work to be performed by the substituted DVBE subcontractor and an identification of the percentage share/dollar amount of the overall contract that the substituted subcontractor will perform.

   4) One or more of the permissible justifications for substituting a DVBE subcontractor as found in 2 C.C.R. § 1896.73(g).

e. Failure of the Contractor to seek substitution and adhere to the DVBE participation level identified in the bid or offer may be cause for contract termination, recovery of damages under rights and remedies due to the State, and penalties as outlined in Mil. & Vet. Code§ 999.9 and other applicable State laws.

f. Upon completion of this Contract, DHCS requires the Contractor to certify using the Prime Contractor's Certification – DVBE Subcontracting Report (STD 817), all of the following:

   1) The total amount the prime Contractor received under the Agreement;

   2) The name, address, Contract number and certification ID Number of the DVBE(s) that participated in the performance of this Contract;

   3) The amount and percentage of work the prime Contractor committed to provide to one or more DVBE(s) under the requirements of the Contract and the total payment each DVBE received from the prime Contractor;

   4) That all payments under the Contract have been made to the DVBE(s); and

   5) The actual percentage of DVBE participation that was achieved. Upon request, the prime Contractor must provide proof of payment for the work.

g. If for this Contract the Contractor made a commitment to achieve the DVBE participation goal, the Department will withhold $10,000 from the final payment, or the full payment if less than $10,000, until the Contractor complies with the certification requirements above. A Contractor that fails to comply with the certification requirement must, after written notice, be allowed to cure the defect. Notwithstanding any other law, if, after at least 15 calendar days but not more than 30 calendar days from the date of written notice, the prime Contractor refuses to comply with the certification requirements, DHCS will permanently deduct $10,000 from the final payment, or the full payment if less than $10,000. (Mil. & Vet. Code § 999.7.)

h. A person or entity that knowingly provides false information will be subject to a

civil penalty for each violation. (Mil. & Vet. Code § 999.5(d); Govt. Code § 14841.)

i. Contractor agrees to comply with the rules, regulations, ordinances, and statutes that apply to the DVBE program as defined in § 999 of the Mil. & Vet. Code, including, but not limited to, the requirements of § 999.5(d).

29. 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 must 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 must take all of the following steps to further this goal.

a. Ensure that small businesses, minority-owned firms and women's business enterprises are used to the fullest extent practicable.

b. 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.

c. 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.

d. 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.

e. 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.

30. Use of Small Business Subcontractors

(Only applicable to agreements awarded in part due to the granting of small business preference where the Contractor committed to use small business subcontractors for at least 25% of the initial contract cost or amount bid.)

a. All Small Business Preference Request attachments and Small Business Subcontractor/Supplier Acknowledgment attachments, however labeled, completed as a condition of bidding, are incorporated herein, and made a part of this Agreement by this reference.

b. Contractor agrees to use each small business subcontractor/supplier, as identified in previously submitted Small Business Preference Request

attachments, unless the Contractor submits a written request for substitution of a like or alternate subcontractor. All requests for substitution must be approved by DHCS, in writing (including email or fax), prior to using a proposed substitute subcontractor.

c. Requests for substitution must be approved by the funding program and must include, at a minimum:

   1) An explanation of the reason for the substitution.

   2) A written description of the business enterprise that will be substituted, including its small business certification status and contact information.

   3) If substitution of an alternate small business does not occur, include a written justification and description of the steps taken to try to acquire a new small business and how that portion of the Contract will be fulfilled.

   4) A written description of the work to be performed by the substituted subcontractor identified by both task (if applicable) and dollar amount or percentage of the overall Contract that the substituted subcontractor will perform. The substituted business, if approved, must perform a commercially useful function in the Contract pursuant to 2 C.C.R. § 1896.15.

d. DHCS may consent to the substitution if allowed by applicable State laws.

e. Prior to the approval of the prime contractor's request for the substitution, the funding program will give notice in writing to the listed subcontractor of the prime contractor's request to substitute and the reasons for the request to substitute. The notice will be served by certified or registered mail to the last known address of the subcontractor. The listed subcontractor that has been so notified will have five (5) working days after the receipt of the notice to submit written objections to the substitution to the funding program. Failure to file these written objections will constitute the listed subcontractor's consent to the substitution. If written objections are filed, DHCS will give notice in writing of at least five (5) working days to the listed subcontractor of a hearing by DHCS on the prime contractor's request for substitution.

f. Failure of the Contractor to subcontract with the small businesses listed in its bid or proposal to DHCS, or failure to follow applicable substitution rules and regulations will be grounds for DGS to impose sanctions pursuant to Gov. Code § 14842.5 and 2 C.C.R. § 1896.92. In the event such sanction are to be imposed, the Contractor be notified in writing and entitled to a hearing pursuant to Gov. Code § 14842. and 2 C.C.R. § 1896.18 and § 1896.20.

g. If requested by DHCS, Contractor agrees to provide documentation/verification, in a form agreed to by DHCS, that small business subcontractor usage under this Agreement complies with the commitments specified during the contractor selection process.

31. Alien Ineligibility Certification

(Applicable to sole proprietors entering into 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.)

32. Union Organizing

(Applicable only to grant agreements.)

Grantee, by signing this Agreement, hereby acknowledges the applicability of Gov. Code §§ 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 must, 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 must provide those records to the Attorney General upon request.

33. Contract Uniformity (Fringe Benefit Allowability)

(Applicable only to nonprofit organizations.)

Pursuant to the provisions of Article 7 (commencing with § 100525) of Chapter 3 of Part 1 of Division 101 of the Health & Saf. 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 must 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.

34. 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 will 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 must 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 will 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 canceled and the Agreement resumes, changes to the services, deliverables, performance dates, and/or contract terms resulting from the suspension or stop work notification will require an amendment to the Agreement.

e. If a suspension or stop work notification is not canceled and the Agreement is canceled or terminated pursuant to the provision entitled Cancellation / Termination, DHCS will allow reasonable costs resulting from the suspension or stop work notification in arriving at the settlement costs.

f. DHCS will not be liable to the Contractor for loss of profits because of any suspension or stop work notification issued under this clause.

35. Public Communications

"Electronic and printed documents developed and produced, for public communications must follow the following requirements to comply with Section 508 of the Rehabilitation Act and the American with Disabilities Act:

a. Ensure visual-impaired, hearing-impaired and other special needs audiences are provided material information in formats that provide the most assistance in making informed choices."

36. Legal Services Contract Requirements

(Applicable only to agreements involving the performance of legal services.)

The Contractor must:

a. Adhere to legal cost and billing guidelines designated by DHCS.

b. Adhere to litigation plans designated by DHCS.

c. Adhere to case phasing of activities designated by DHCS.

d. Submit and adhere to legal budgets as designated by DHCS.

e. Maintain legal malpractice insurance in an amount not less than the amount designated by DHCS. Said amount must be indicated in a separate letter to the Contractor.

f. Submit to legal bill audits and law firm audits if requested by DHCS. Such audits may be conducted by State employees or its designees or by any legal cost control providers retained by DHCS for such purpose.

g. Applicable only to legal agreements of $50,000 or more:

   Contractor agrees to make a good faith effort to provide a minimum number of hours of pro bono legal services during each year of the contract equal to the lesser of 30 multiplied by the number of full time attorneys in the firm's offices in the State, with the number of hours prorated on an actual day basis for any contract period of less than a full year or 10% of its contract with the State.

   Failure to make a good faith effort may be cause for non-renewal of a state contract for legal services, and may be taken into account when determining the award of future contracts with the State for legal services.

37. Compliance with Statutes and Regulations

a. The Contractor must comply with all California and federal law, regulations, and published guidelines, to the extent that these authorities contain requirements applicable to Contractor's performance under the Agreement. This includes any changes to the applicable laws, regulations, and/or published guidelines that arise after the execution of this Agreement.

b. For federally funded agreements, these authorities include, but are not limited to, 2 C.F.R. Part 200, subpart F, Appendix II; 42 C.F.R. Part 431, subpart F; 42 C.F.R. Part 433, subpart D; 42 C.F.R. Part 434; 45 C.F.R. Part 75, subpart D; and 45 C.F.R. Part 95, subpart F. To the extent applicable under federal law, this Agreement will incorporate the contractual provisions in these federal regulations and they will supersede any conflicting provisions in this Agreement.

38. 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, must 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 must 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 non-appropriated 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 must 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 must file a certification, and a disclosure form, if required, to the next tier above.

5) All disclosure forms (but not certifications) must be forwarded from tier to tier until received by the person referred to in Paragraph a(1) of this provision. That person must 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 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 37
CERTIFICATION REGARDING LOBBYING

The recipient 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 must complete and submit Standard Form LLL, “Disclosure of Lobbying Activities" (Attachment 2) in accordance with its instructions.

3. The recipient must 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 must 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 will be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

By signing or otherwise accepting the Agreement, the recipient certifies and files this Attachment 1. **CERTIFICATION REGARDING LOBBYING,** as required by Section 1352, Title 31, U.S.C., unless the conditions stated in paragraph 2 above exist. In such case, the awardee/contractor must complete and sign Attachment 2. **CERTIFICATION REGARDING LOBBYING and returning it to the Department of Health Care Services.**

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:	2. Status of Federal Action:	3. Report Type:
_ a. contract b. grant c. cooperative agreement d. loan e. loan guarantee f. loan insurance	_ a. bid/offer/application b. initial award c. post-award	_ a. initial filing b. material change For Material Change Only: Year _____ quarter _____ date of last report _____.

4. Name and Address of Reporting Entity:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:
☐ Prime ☐ Subawardee Tier ___, if known: Congressional District, If known:	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 Number:	
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 follow up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.

4. Enter the full name, address, city, State and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if 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 grant.

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.

EXHIBIT E: ADDITIONAL PROVISIONS

1. ADDITIONAL INCORPORATED EXHIBITS

For purposes of this Provision, the term "Contract" refers to the combined Request for Proposal (RFP) 23-30001 Medi-Cal Dental Managed Care Plans, all related State and/or Department of Health Care Services (DHCS) formal documents, and all listed Exhibits and Attachments. In the event there are inconsistencies or ambiguities between the Contractor's Narrative Proposal (NP) and the Contract, or if the NP does not address Contract requirements, the Contract will govern the NP. Only in those instances where the NP has offered to meet more stringent requirements than those required in the Contract and DHCS has indicated, in writing, its approval of the more stringent requirements, shall the NP prevail.

A. The following documents are not attached, but are incorporated herein, and made a part hereof, by this reference. DHCS shall provide the Contractor with copies of said documents under separate cover. DHCS will maintain, on file, all documents referenced herein.

1. The Contractor's Narrative Proposal

2. AMENDMENT AND CHANGE ORDER PROCESS

In addition to EXHIBIT C: GENERAL TERMS AND CONDITIONS, 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. The other party shall acknowledge receipt of the proposal within ten (10) calendar days of receipt of the proposal. The party proposing any such change shall have the right to withdraw the proposal any time prior to acceptance or rejection by the other party. Any proposal shall set forth an explanation of the reason and basis for the proposed change and the text of the desired amendment to this Contract which would provide for the change. If the proposal is accepted, this Contract shall be amended to provide for the change mutually agreed to by the parties on the condition that the amendment is approved by DHCS, and the State Department of Finance, if necessary.

3. TERMINATION

3.1. 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.

3.2. TERMINATION WITH CAUSE - STATE

a. DHCS shall terminate this contract pursuant to the provisions of Welfare and Institutions Code Section 14197.7 and 22 CCR 53352.

b. 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.

c. 42 CFR § 438.710 requires that DHCS must provide the Contractor a pre-termination hearing before terminating the contract under 42 CFR § 438.708.

d. 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.

e. 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.

f. DHCS shall terminate the contract for Contractor's non-compliance with CAP recommendations agreed upon by the Contractor and DHCS.

3.3. TERMINATION WITHOUT CAUSE - CONTRACTOR

a. 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.

b. 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 SECTION 17. PHASEOUT REQUIREMENTS.

3.4. 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 SECTION 17. PHASEOUT REQUIREMENTS, which shall be performed after contract termination.

3.5. 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.

3.6. PROHIBITED CONTRACTS DUE TO TERMINATION

Any contractor terminated for cause 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.

3.7. NOTICE OF PRE-TERMINATION HEARING

The State must:

a. Provide the contractor written notification of its intent to terminate, the reason for termination, and the time and place of the hearing;

b. 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

c. 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 shall give the Contractor's Members written notice of DHCS' intent to terminate, and to allow Members to disenroll immediately without cause.

3.8. SPECIAL RULES FOR TEMPORARY MANAGEMENT

The State may impose temporary management if it finds there is:

a. 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 substantive requirements 1903(m) and 1932 of the Social Security Act,

b. There is a substantial risk to members' health, or

c. If it is necessary to ensure the health of members. 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 provision replaces and supersedes SECTION 16. DISPUTE RESOLUTION PROCESS of EXHIBIT D: SPECIAL TERMS AND CONDITIONS.

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.

1. 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.

2. 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:

a. That it is a dispute pursuant to this section.

b. The date, nature, and circumstances of the conduct which is subject of the dispute.

c. The names, phone numbers, function, and activity of each Contractor, subcontractor, DHCS/State official, or employee involved in or knowledgeable about the conduct.

d. The identification of any documents and the substances of any oral communications involved in the conduct. Copies of all identified documents will be attached.

e. The reason the Contractor is disputing the conduct.

f. The cost impact to the Contractor directly attributable to the alleged conduct, if any.

g. 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.

3. 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 Plans. 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.

4. Within thirty (30) calendar days of receipt of a Notification of Dispute, the Contracting Officer or the alternate dispute officer shall either:

    a. Find in favor of Contractor, in which case the Contracting Officer or alternate dispute officer may:

        i. Countermand the earlier conduct which caused Contractor to file a dispute; or

        ii. 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 & PAYMENT PROVISIONS, direct DHCS to comply with that Exhibit; or,

    b. Deny Contractor's dispute and, where necessary, direct the manner of future performance; or

    c. Request additional substantiating documentation in the event the information in Contractor's notification is inadequate to permit a decision to be made under a) or b) above, 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 7. Waiver of Claims, below.

    A copy of the decision shall be served on Contractor.

5. 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 2. 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 7, Waiver of Claims below, Contractor shall exhaust all procedures provided for Dispute Resolution Process prior to initiating any other action to enforce this Contract.

6. 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 5, 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 f 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.

7. 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 Dispute Resolution Negotiations, above, 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: GENERAL TERMS AND CONDITIONS, Provision 14, Governing Law, Contractor also agrees to the following:

1. 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 SECTION 18. SANCTIONS, and SECTION 19. LIQUIDATED DAMAGES PROVISIONS, 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.

2. 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 SECTION 3.3. TERMINATION WITHOUT CAUSE - CONTRACTOR. The parties shall be bound by the terms of the amendment until the effective date of the termination.

3. 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.

4. Contractor must comply with all DHCS guidance, including but not limited to All Plan Letters (APLs), Policy Letters (PLs), the State Plan, and the Medi-Cal Dental Provider Handbook.

   a. APLs and PLs

      i. Contractor must comply with all existing and future APLs and PLs.

      ii. APLs and PLs existing on the effective date of the Contract will be considered part of the Contract as if fully set forth herein.

      iii. APLs and PLs issued or revised subsequent to the effective date of the Contract provide clarification of existing contractual obligations and instructions regarding implementation of mandated obligations, including but not limited to implementation of changes in State or federal statutes or regulations, or pursuant to judicial interpretation.

      iv. APLs issued by DHCS pursuant to statutory authority to issue guidance in lieu of

regulations will have the same force and effect as regulations and may set forth new obligations.

b. In the event DHCS determines that there is an inconsistency between this contract and an APL, the APL 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 SECTION 2. AMENDMENT AND CHANGE ORDER 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

8.1. GENERAL PROVISIONS

The parties recognize that during the life of this contract, the Medi-Cal Dental 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 SECTION 2. AMENDMENT AND CHANGE ORDER PROCESS.

8.2. 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.

8.3. 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.

8.4. AD HOC REPORTING

DHCS intends to implement this contract through a single administrator, called the "Contracting Officer." The Director of DHCS will appoint 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. The Contracting Officer may delegate his/her authority to act to an authorized representative through written notice to the Contractor.

9. DELEGATION OF AUTHORITY

DHCS intends to implement this contract through a single administrator, called the "Contracting Officer." The Director of DHCS will appoint 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. The Contracting Officer may delegate his/ her authority to act to an authorized representative through written notice to the Contractor.

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 SECTION 13. NOTICES. The Contractor's Representative, on behalf of the Contractor, 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 DHCS.

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 Plans 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 Plans 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 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:

Medi-Cal Dental Services Division
Attention: XXX, XXX
Telephone: (XXX) XXX-XXXX
1501 Capitol Avenue, MS 4900
P.O. Box Number 997413
Sacramento, CA 95899-7413
Telephone: (XXX) XXX-XXXX
Email: XXX@dhcs.ca.gov

Plan Name.
Attention: XXX
Phone: (XXX) XXX-XXXX
Email: XXX

14. CONTRACT TERM

The term of the resulting agreement(s) (Contract Term) is expected to be fifty-four months (54) months and shall commence on the Contract Execution Date (CED) which is anticipated to be June 12, 2024, with the operations period required to be effective July 1, 2025. The Contract Term may change if DHCS makes an award earlier than expected or if DHCS cannot execute the agreement(s) in a timely manner due to unforeseen delays.

DHCS reserves the right to extend the Contract Term via an amendment as necessary to complete or continue the services. Any extensions to the Contract Term are subject to satisfactory performance, funding availability, and possibly approval by any necessary department or agency. DHCS offers no assurance that an extension of the Contract Term will occur or that funding will be continued at the same level in future years.

The resulting Contract will be of no force or effect until it is signed by both parties and approved by CMS, if required. The Contractor is hereby advised not to commence performance until all approvals have been obtained and the Contractor receives approval, in writing, from DHCS to begin work. Should performance commence before all approvals are obtained, said services shall be considered to have been volunteered by the Contractor.

15. CONTRACT EXTENSION

DHCS may extend the Contract, up to five (5) years using individual one-year optional extensions or multi-year extensions at its sole discretion. This is separate from the additional time as necessary to phase out the operations of the contract. DHCS reserves the right to exercise such extensions but shall have no obligation to do so.

During the period of extended operations, the Contractor’s responsibilities shall remain the same as defined in the Contract. Contract extensions are at DHCS’ sole discretion and are subject to satisfactory performance of EXHIBIT A: SCOPE OF WORK (SOW) requirements, funding availability and approval by DGS, if applicable. DHCS reserves the right to extend the term of the resulting agreement(s) via an amendment as necessary to complete or continue the services. Contract extensions are subject to satisfactory performance, funding availability, and possibly approval by any necessary department or agency. DHCS offers no assurance that an extension will occur or that funding will be continued at the same level in future years.

16. SERVICE AREA

The Service Area covered under this Contract includes:

Geographic Managed Care – Sacramento County

17. PHASEOUT REQUIREMENTS

1. DHCS will retain Capitation Payment for each Service Area from the Contractor's Capitation Payment for the last four months of the Operations Period for each Service Area, or the Contractor must provide a performance bond to DHCS of an equal amount, until all financial obligations under this Contract have been completed and all activities required during the Phaseout Period for each Service Area are fully completed to the satisfaction of DHCS, in its sole discretion.

   Upon completion of all financial obligations under this Contract and the completion of all Phaseout Period activities for each Service Area, the withhold will be paid to the Contractor or the performance bond will be released. If the Contractor fails to meet any requirement(s) by the end of the Phaseout Period for each Service Area, DHCS will deduct the estimated costs of the remaining activities from the withheld amount and continue to withhold payment until all activities are completed.
2. 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.
3. 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.

4. Phaseout Period will commence on the date the Operations Period of the contract or contract extension ends. Phaseout related activities are non-payable items.
5. Contractor shall submit a final undisputed payment invoice as soon as practical following the end of the Operations Period or contract termination, whichever comes first. The invoice must be clearly marked “Final Invoice” and accompanied by the Contractor’s Release form in EXHIBIT F: CONTRACTOR'S RELEASE 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 pursuant to Welfare and Institutions Code Section 14197.7 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.

Determination of non-compliance may be based on findings from onsite surveys, Member 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 14197.7.

1. A contractor may request a hearing in connection with any sanctions applied pursuant to Welfare and Institutions Code Section 14197.7(d) 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.

2. Sanctions for violations of the requirements of SECTION 4. QUALITY IMPROVEMENT AND ORAL HEALTH ACCESS TRANSFORMATION PROGRAM (QIOHATP) shall be governed by
   Welfare & Institutions Code Section 14197.7.

3. For purposes of sanctions, good cause includes, but is not limited to, the following:

a. 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.

b. In the case of SECTION 5. PERFORMANCE MEASURES, QUALITY METRICS, 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.

c. A substantial failure to provide medically necessary covered services required under this contract or law to a Member.

d. Imposition on Members for charges that are in excess of the charges permitted under the Medi-Cal program.

e. 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.

f. Misrepresentation or falsification of information furnished to CMS or to DHCS.

g. Misrepresentation or falsification of information furnished to a Member, potential Member, or health care provider.

h. Non-compliance with the contract or applicable Federal and State law or regulation.

i. Violation of any of the requirements under sections 1903(m) or 1932 of the Social Security Act.

j. Failure to comply with requirements for physician incentive plans as set forth in 42 CFR 422.208 and 422.210.

k. The direct or indirect distribution of marketing materials that have not been approved by DHCS, or that contain false or materially misleading information.

l. Contractor has accrued claims that have not or will not be recompensed.

4. Upon determinations of non-compliance, DHCS may impose the following sanctions:

a. Granting and notification of Members the right to terminate enrollment without cause.

b. 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.

c. 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.

5. 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.

   a. Civil money penalties pursuant as provided in SECTION 11. FULFILLMENT OF OBLIGATIONS.

   b. Appointment of temporary management as provided in SECTION 11. FULFILLMENT OF OBLIGATIONS.

6. 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.

7. 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:

   a. Suspend marketing activities.

   b. Require the contractor temporarily to suspend specified personnel.

   c. Require the contractor temporarily to suspend participation by a specified subcontractor.

8. Upon receipt of a notice 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.

9. 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 the U.S. Department

of Health and Human Services (DHHS)under 42 CFR 438.730.

10. 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.

    a. 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.

    b. 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.

    c. The limit is fifteen thousand dollars ($15,000) for each beneficiary the State determines was not enrolled due to discriminatory practices.

    d. The limit is twenty-five thousand dollars ($25,000) or double the amount of the excess charges, whichever is less, for each determination of that Members' premiums or charges are in excess of the premiums or charges permitted under Medi-Cal, whichever is less.

11. The Director shall have the power and authority to take one or more of the following sanctions against Contractor for noncompliance:

    a. 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.

    b. Suspension of all new enrollment, including default enrollment, or marketing activities after the effective date of the sanction.

    c. Require Contractor to temporarily suspend or terminate personnel or subcontractors.

    d. 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:

i. Five thousand dollars ($5,000) for the first violation.

ii. Ten thousand dollars ($10,000) for the second violation.

iii. The limit is twenty-five thousand dollars ($25,000) for each subsequent violation.

e. Collect civil penalties by withholding the amount from capitation owed to the Contractor.

f. Take other appropriate action as determined necessary by DHCS.

19. LIQUIDATED DAMAGES PROVISIONS

19.1. 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 SECTION 19.2. LIQUIDATED DAMAGES FOR VIOLATION OF CONTRACT TERMS REGARDING THE IMPLEMENTATION PERIOD, SECTION 19.3. 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 contract requirement(s) needing 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 SECTION 19.2. 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 SECTION 19.3. 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 SECTION 19.3. 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.

19.2. 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 SECTION 14. CONTRACT 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.

19.3. LIQUIDATED DAMAGES FOR VIOLATION OF CONTRACT TERMS OR REGULATIONS REGARDING THE OPERATIONS PERIOD

a. Site Reviews

   DHCS may impose liquidated damages of $2,500 per day for each violation of contract requirement not performed in accordance with SECTION 12. SITE REVIEW, until the contract requirement is performed or provided.

b. 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 SECTION 26. THIRD-PARTY TORT AND WORKER'S COMPENSATION LIABILITY.

c. Plan Provider Availability

   DHCS may impose liquidated damages of $3,500 per violation of contract requirement not performed in accordance with EXHIBIT A8: PROVIDER NETWORK, SECTION 7. NETWORK PROVIDER AVAILABILITY.

d. 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 G: HIPAA BUSINESS ASSOCIATE ADDENDUM.

19.4. 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.

19.5. 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 SECTION 20. 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.

20.1. 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.

20.2. 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 for a minimum of 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, US 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

1. The Contractor must comply with any State-conducted readiness review.

2. Readiness reviews must include both a desk review of documents and on-site reviews of the Contractor. Readiness reviews described in Provision 3 of this section must include a desk review of documents and may, at DHCS's option, include an on-site review. Onsite reviews must include interviews with the Contractor staff and leadership that manage key operational areas.

3. The DHCS readiness review will assess the ability and capacity of Contractor (if applicable) to perform satisfactorily for the following areas:

    a. Operations/Administration, including but not limited to:

        i. Administrative staffing and resources.
        ii. Delegation and oversight of MCO, PIHP, PAHP or PCCM entity responsibilities.
        iii. Member and provider communications.
        iv. Grievance and appeals.
        v. Member services and outreach.
        vi. Provider Network Management.
        vii. Program Integrity/Compliance

    b. Service delivery, including:

        i. Case management/care coordination/service planning.
        ii. Quality improvement.
        iii. Utilization review.

    c. Financial management, including:

        i. Financial reporting and monitoring.
        ii. Financial solvency.

d. Systems management, including:

i. Claims management.
ii. Encounter data and enrollment information management

22. INSPECTION RIGHTS

In addition to EXHIBIT D: SPECIAL TERMS AND CONDITIONS, SECTION 8. SITE INSPECTION Contractor also agrees to the following:

Through the end of the records retention period specified in SECTION 20.2. RECORDS RETENTION, Contractor shall allow the DHCS, US 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 nondental services rendered to Members. Upon request, through the end of the records retention period specified in SECTION 20.2. 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.

22.1. 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 statutes and regulations, and contract requirements.

22.2. 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. CONFIDENTIALITY OF MEMBER INFORMATION

In addition to EXHIBIT D: SPECIAL TERMS AND CONDITIONS, SECTION 14. CONFIDENTIALITY OF INFORMATION and EXHIBIT G: HIPAA BUSINESS ASSOCIATE ADDENDUM, Contractor also agrees to the following duties and responsibilities with respect to confidentiality of information and data:

1. 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.

2. 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. 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 SECTION 2. AMENDMENT AND CHANGE ORDER PROCESS.

25. COST AVOIDANCE AND POST-PAYMENT RECOVERY (PPR) OF OTHER HEALTH COVERAGE (OHC)

1. Contractor shall Cost Avoid or make a PPR for the reasonable value of services paid by Contractor and rendered to a Member whenever a Member's OHC covers the same services, fully or partially. However, in no event shall Contractor Cost Avoid or seek PPR for the reasonable value of services from a Third-Party Tort Liability (TPTL) action or make a claim against the estates of deceased Members.

2. Contractor shall rely on the Medi-Cal eligibility record for Cost Avoidance and PPR purposes

3. Cost Avoidance

    a. Contractor shall coordinate benefits with other coverage programs or entitlements, recognizing the OHC as primary and the Medi-Cal program as the payer of last resort, except for services in which Medi-Cal is required to be the primary payer

    b. Contractor shall not pay claims for services provided to a Member whose Medi-Cal eligibility record indicates dental third-party coverage, designated OHC code with a Scope of Coverage "D" indicator as reflected in the Medi-Cal eligibility record, without proof that the provider has first exhausted all sources of other payments. Acceptable forms of proof that all sources of payment have been exhausted or do not apply include a denial letter from the OHC for the service, an explanation of benefits indicating that the service is not covered by the OHC, or documentation demonstrating that the Provider has billed the OHC and received no response for at least 90 calendar days.

        i. Contractor shall ensure that Providers do not refuse to provide Covered Services to Members, when OHC is indicated on a Member's Medi-Cal eligibility record.

        ii. Contractor must allow Providers to direct bill services that meet DHCS' requirements for direct billing without attempting to Cost Avoid these services. Cost

Avoidance not required prior to payment for services provided to Members with OHC codes A or N.

iii. Prior to delivering services, Contractor must ensure that Providers review the Member's Medi-Cal eligibility record for dental third-party coverage, designated by OHC code with a Scope of Coverage "D" indicator as reflected in the Medi-Cal eligibility record. If the Member's Medi-Cal eligibility record indicates OHC with the Scope of Coverage "D" and the requested service is covered by OHC, Contractor must ensure that Providers notify the Member to seek the service from OHC.

iv. When Contractor denies a claim due to OHC, Contractor must include OHC information in its notice of claim denial to Provider. OHC information includes, but is not limited to, the name of the OHC or Medicare carrier, and contact or billing information of the OHC.

4. Reporting Requirement for Cost Avoidance

Contractor must report new OHC information found on the Medi-Cal eligibility record or that is different from what is reflected on the Medi-Cal eligibility record to DHCS within ten (10) calendar days of discovery. Contractor must report discrepancies in the Medi-Cal record by either completing and submitting an OHC removal or addition form found online at https://www.dhcs.ca.gov/services/Pages/TPLRD_OCU_cont.aspx or reporting OHC information to DHCS in batch updates. Batch updates regarding OHC information are processed by DHCS on a weekly basis. Contractor may contact its DHCS Contract Manager for more information regarding this process

5. Post-Payment Recovery (PPR)

Contractor retains all monies for PPR recovered when contractor initiates and completes recovery within 12 months from the date of payment of service. Any monies for PPR obtained after the 12 months following the date of payment of a service are considered Medi-Cal recoveries and must be remitted to DHCS.

When Contractor discovers that a service was provided to a Member with an OHC Code and Scope of Coverage indicator "D" is reflected in the Medi-Cal eligibility record, or becomes aware of other dental third-party coverage, and Contractor did not properly Cost Avoid the service, then Contractor must bill the OHC for the cost of actual services rendered.

Contractor must bill the liable OHC for the cost of the services provided to the Members. Billing and recoupment must be completed within 12 months from the date of payment of a service.

Monies recovered by DHCS or DHCS' contracted recovery agent starting on the first day of the 13th month after the date of payment of a service will be retained by DHCS.

If contractor does not perform PPR for a member with OHC, Contractor must demonstrate to DHCS, upon request, that the cost of PPR exceeds the total Contract Revenues Contractor projects it would receive from such an activity.

a. Reporting Requirements for PPR

i. Contractor shall maintain reports that display claims counts and dollar amounts of costs avoided and the amount of post-payment recoveries, as well as the amount of outstanding recovery claims (accounts receivable) by age of account. Reports shall be made available upon DHCS request.
ii. Contractor shall submit a monthly PPR Report to DHCS via Secure File Transfer Protocol (SFTP) by the 15th day of each month in a format specified by DHCS in applicable All Plan Letter(s). This report must contain claims and recovery information and any other information specified by DHCS in applicable All Plan Letter(s).
iii. If Contractor does not cost avoid or perform PPR for a member with OHC, Contractor shall demonstrate to DHCS, upon request, that the cost of cost avoidance or PPR exceeds the total revenues Contractor projects it would receive from such activity.
iv. Contractor must have written policies and procedures implementing all of the requirements of this provision, subject to review and approval at DHCS request.

26. THIRD-PARTY TORT AND WORKER'S COMPENSATION LIABILITY

Contractor must not make a claim for recovery of the value of Covered Services rendered to a member in or instances involving casualty insurance, tort, Workers' Compensation, or class action claims. To assist DHCS in exercising DHCS' exclusive responsibility for recovering casualty insurance, tort, Workers' Compensation, or class action claims, Contractor must:

1. Within 30 days of DHCS' request, submit all requested service and utilization information and, when requested, copies of paid invoices/claims for its Members, including information from Network Providers, Out-of-Network Providers, and Subcontractors. Service and utilization information and copies of paid invoices/claims must set out any services provided by Contractor, including, but not limited to, physical, mental, and dental health services. Records must include services provided on a Fee-for-Service (FFS), capitated basis, and any other payment arrangements, regardless of whether a payment was made or denied. The reasonable value of the

services must be calculated as the usual, customary, and reasonable charge made to the general public for similar services or the amount paid to Network Providers or Out-of- Network for similar services. No additional payment will be made to Contractor for compliance with this provision.

2. Provider service and utilization information and, when requested, copies of paid invoices/claims that contain a minimum of, but not limited to, the following data elements:

    a. Name of the Managed Care Plan/Independent Physician's Association

    b. Member Name

    c. Member Date of Birth (provided by DHCS)

    d. Client Index Number (CIN)

    e. Date of Injury

    f. Claim Control Number (CCN)

    g. Claim Line Number

    h. Claim Type

    i. Service From Date

    j. Service To Date

    k. Legal Name

    l. National Provider Identifier (NPI)

    m. Diagnosis Code 1 (Primary Diagnosis)

    n. Diagnosis Code 2 (Secondary Diagnosis)

    o. Drug Label Name (if applicable)

    p. Amount Billed

    q. Amount paid (The actual amount the MCP paid to the provider for services. If the service is

capitated, indicate amount as “0”)

r. Reasonable Value (Absent the “Amount Paid”, due to capitated or other service type, the “Reasonable Value” of the service must be provided, pursuant to Title 28, California Code of Regulations (CCR), section 1300.71(a)(3))

s. Current Dental Terminology (CDT) Code or Current Procedural Terminology (CPT Code)

t. Claim Deny Reason Code 1 and Description (if applicable) Claim Deny Reason Code 2 and Description (if applicable)

Required data items and delivery requirements may be subject to change as outlined by the issuance of any applicable All Plan Letter(s).

3. Notify DHCS’ at TPLManagedCare@dhcs.ca.gov of the name, address, email address, and telephone number of the person responsible for receiving deliveries and with requests for mandatory and/or optional at-risk service information.

4. Notify DHCS using the appropriate online notification form at https://Forms within ten (10) days of receiving requests from attorneys, insurers, or Members for a lien, pursuant to DHCS’ recovery rights. These requirements do not relieve Contractor of other legal duties to Contractor’s Members or other entities, including, without limitation, the duty to respond to Members’ requests for their own Protected Health Information (PHI) pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

5. Use the TPLManagedCare@dhcs.ca.gov inbox for all communications regarding Contractor’s service and utilization information and paid invoices/claims submissions and to submit questions or comments related to the preparation and submission of these reports.

6. Have written policies and procedures implementing all requirements of this provision, subject to review and approval at DHCS’ request.

7. Contractor’s failure to comply with this provision is non-delegable. In the event that Contractor’s failure to comply with this section negatively impacts DHCS’ ability to recover its full statutory lien, DHCS reserves the right to deduct any losses from the Contractor’s managed care payments.

27. RECORDS RELATED TO RECOVERY FOR LITIGATION

27.1. 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 under this contract.

28. FRAUD, WASTE AND ABUSE

1. For purposes of this provision, see EXHIBIT E1: DEFINITIONS, for abuse, conviction or convicted and fraud.

2. 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.

    a. 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:

        i. Effective training and education for the Compliance Officer and the organization's employees.

        ii. Effective lines of communication between the Compliance Officer and the organization's employees. Enforcement of standards through well-publicized disciplinary guidelines.

iii. 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.

iv. Provision for prompt response to detected offenses, and for development of corrective action initiatives.

3. 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 fraud, waste and/or abuse to DHCS' Medi-Cal Program Integrity Unit for the DMC plans. The preliminary investigation and all documents regarding the investigation shall be reviewed by a licensed dentist.

a. Fraud, waste, and/or abuse reports must be submitted to DHCS' Audits and Investigations (A&I) Intake Unit, and must, at a minimum, include:

i. Number of complaints of fraud and abuse submitted that warranted preliminary investigation.

ii. For each complaint which warranted a preliminary investigation, supply:

1. Name and/or SSN or CIN;
2. Source of complaint;
3. Type of provider (if applicable);
4. Nature of complaint;
5. Approximate dollars involved; and
6. Legal and administrative disposition of the case.

iii. The report shall be submitted on a Confidential Medi-Cal Complaint Report (MC 609) that can be sent to DHCS in one of three ways:

1. Email at: PIU.Cases@dhcs.ca.gov
2. E-fax at (916) 440-5287
3. U.S. Mail at:
   Department of Health Care Services
   Medi-Cal Dental Services Division
   P.O. Box 997413, Mail Stop 4900
   Sacramento, CA 95899-7413

iv. 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.

v. DHCS will follow-up with the DMC Plan throughout the duration of the investigation for status updates. DMC Plans are required to provide A&I the results, outcomes, and resolutions of the investigation within ten (10) business days after completing the investigation.

vi. 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.

vii. Contractor employees shall be given written policies regarding the False Claims Act and about their rights to be protected as whistleblowers.

4. Overpayments Recovery

a. Contractor shall promptly report to DHCS in accordance with SECTION 28. FRAUD, WASTE AND ABUSE all overpayments identified or recovered, specifying the overpayments due to potential fraud.

b. Contractor shall create an internal retention and documentation process for recovery of all overpayments and review bi-annually for accuracy.

c. Recoveries less than $1 million. The DMC Plan shall retain all overpayment recoveries less than $1 million. The DMC Plan is not required to report an overpayment of less than $1 million to DHCS within 60 calendar days of when the overpayment was identified.

d. Recoveries equal to or more than $1 million. The contractor shall split equally all overpayment recoveries of $1 million or more with DHCS. The contractor must report an overpayment of $1 million or more to DHCS through Medi-Cal Dental Services Division at dmcdeliverables@dhcs.ca.gov within 60 calendar days of the date that the overpayment of $1 million or more was identified, and provide the following information:

    i. The overpayment amount that was recovered.
    ii. The reason for the overpayment.
    iii. The services the overpayment was related to, if applicable.
    iv. The provider(s) information; and
    v. The steps taken to correct future occurrences.

e. DHCS will work directly with the contractor to either recoup the overpayment from the contractor's capitated payment and reflect the overpayment in the statement issued to the contractor or require a check or wire from the contractor.

f. Recoveries of any amount in the event a contractor identifies or recovers an overpayment to a provider due to potential fraud, the contractor must notify DHCS within ten days of identifying the overpayment, regardless of the amount.

g. Recoveries retained under False Claims Act cases or through other investigations are not subject to this policy.

h. 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 & PAYMENT PROVISIONS, SECTION 10. FINANCIAL PERFORMANCE GUARANTEE.

5. Changes in Eligibility

   Contractor shall promptly report to DHCS in accordance with SECTION 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.

6. 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.

7. 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 online 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 (https://sam.gov/content/exclusions); and provider shall not be found on the Social Security Administration's Death Master File (https://www.ssa.gov/dataexchange/request_dmf.html). 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. A removed, suspended, excluded, or terminated provider report can be sent to DHCS in one of three (3) ways:

   a. Email at PIUCases@DHCS.ca.gov;
   b. E-fax at (916) 440-5287; or
   c. U.S. Mail at:
      Department of Health Care Services
      Managed Care Operations Division

Attention: Chief, Program Integrity Unit
MS 4417
P.O. Box 997413
Sacramento, CA 95899-7413

8. 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. 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.

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.

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 neutral 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 E1: 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 Medi-Cal 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 Member practices that result in unnecessary cost to the Medi-Cal program

Administrative Costs means only those costs that arise out of Contractor's operations as specified in 28 CCR section 1300.78.

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 SECTION 2. ENROLLMENT.

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.

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 Payment means a regularly scheduled payment made by DHCS to the Contractor on behalf of each Member for each month the Member is enrolled with the Contractor that is based on the actuarially sound capitation rate for the provision of Covered Services, and paid regardless of whether a Member receives services during the period covered by the payment.

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 Members 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 Dental Benefit Coverage means a dental plan that provides coverage for dental services which broadly or completely meet a member's dental needs.

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 Contractor.

Contract Revenues means the amount of Medi-Cal managed care Capitation Payments and other revenue paid to Contractor by DHCS under this Contract.

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 Contractor that address program deficiencies or problems identified by formal audits or monitoring activities by the State or its designated representatives.

Cost Avoid means a deliberate intervention that reduces or eliminates a cost to the Medi-Cal program that would have otherwise occurred if not for the use of that intervention.

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), Centers for Medicare & Medicaid Services (CMS) 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 Dental Services 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.

Directed Payment Initiative means a payment arrangement that directs certain expenditures made by Contractor under this Contract that is either approved by CMS as described in 42 CFR Section 438.6(c), or established pursuant to 42 CFR Sections 438.6(c)(1)(iii)(A) and 438.6(c)(2)(ii) and documented in a rate certification approved by CMS.

Director means the Director of the State of California Department of Health Care Services.

Early and Periodic Screening, Diagnostic, & Treatment (EPSDT) is a Medi-Cal benefit for individuals under the age of 21 who have full-scope Medi-Cal eligibility. This benefit allows for periodic screenings to determine health care needs. Based upon the identified health care need and diagnosis; treatment services are provided to correct or ameliorate defects and chronic conditions.

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 (existing at the release of the RFP):

Aid Group	Mandatory Aid Codes	Non-Mandatory Aid Codes
Family	01, 02, 08, 0A, 0G, 2V 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, 76, 7A, 7J, 7L, 7S, 7W, 7X, 82, 8E, 8P, 8R, 8U, E6, E7, K1, L6, M7, M9, R1	03, 04, 07, 40, 42, 43, 45, 49, 4A, 4F, 4G, 4H, 4K, 4L, 4M, 4N, 4S, 4T, 4W, 5K
Adult Expansion	7U, E2, E5, L1, M1, M3, M5, P5, P7, P9, T1, T2, T3, T4, T5	
Aged	10, 13 14, 16, 1E, 1H, 1X	06, 46
Disabled	20, 23, 24, 26, 2E, 2H, 36, 53, 60, 63, 64, 66, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6V, 6X	
Adult	81, 86	

Child	5C, 5D, H1, H2, H3, H4, H5	
Breast and Cervical Cancer Treatment Program (BCCTP)	0M, 0N, 0P, 0R, 0T, 0U, 0W	

For the purposes of this Contract, “Eligible Beneficiary” shall have the same meaning as “Member” and “Enrollee”.

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 Member who is currently enrolled in an MCO, PIHP, PAHP, PCCM, or PCCM entity in a given managed care program. For the purposes of this Contract, “Enrollee” shall have the same meaning as “Member” and “Eligible Beneficiary.”

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 Contractor or its Affiliates for purposes related to this Contract, or
B. Maintained by a Provider to provide services on behalf of Contractor.

Federal Financial Participation (FFP) means federal expenditures provided to reimburse allowable State expenditures made under the approved California Medicaid State Plan, waivers, or other similar federal Medicaid authority.

Federally Qualified Health Center (FQHC) means an entity defined in Section 1905 of the Social Security Act. (42 USC 1396d(l)(2)(B).)

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 reports prepared by the Contractor to present its financial performance and position at a point in time, and include 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 twelve (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; Welfare & Institutions Code §14043.1(i).)

Fully Delegated Subcontractor means a Subcontractor that contractually assumes all duties and obligations of Contractor under the Contract, except for those contractual duties and obligations where delegation is legally or contractually prohibited. A dental managed care plan can operate as a Fully Delegated Subcontractor.

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.

Incentive Arrangement means any payment mechanism approved by CMS in accordance with 42 CFR section 438.6(b) under which the Contractor may receive incentive payments in addition to Capitation Payments for meeting targets specified in accordance with this Contract, including but not limited to Exhibit B, Provision N (Special Contract Provisions Related to Payment).

Indian Health Care Providers (IHCP) means a health care program operated by the Indian Health Service (HIS) 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. Section 1603 and 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 of the California 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:

A. A Federally qualified HMO that meets the advance directives requirements of subpart I of part 489 of this chapter; or
B. Any public or private entity that meets the advance directives requirements and is determined by the Secretary to also meet the following conditions:
    1. 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.
    2. 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 Social Security 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 Contractor where information regarding the services offered by Contractor is disseminated in order to persuade Eligible Beneficiaries to enroll in Contractor's plan. Marketing also includes any similar activity to secure the endorsement of any individual or organization on behalf of Contractor.

Marketing Representative means a person who is engaged in marketing activities on behalf of Contractor.

Measurement Year means the timeframe beginning January 1st and continuing for twelve (12) months thereafter.

Medi-Cal Eligibility Data System (MEDS) means the automated eligibility information processing system operated by the State which provides online access for member information, update of member eligibility data and online 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, "Member" shall have the same meaning as "Enrollee" and "Eligible Beneficiary".

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:

A. 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
B. 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 their membership from birth to one (1) year old.

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.

Oral Health Disparity means differences in oral health outcomes closely linked with social, economic, and environmental disadvantage, which are often driven by the social conditions in which individuals live, learn, work, and play. Characteristics such as race, ethnicity, age, disability, sexual orientation or gender identity, socio-economic status, geographic location, and other factors historically linked to exclusion or discrimination are known to influence the oral health of individuals, families, and communities.

Oral Health Access means the reduction or elimination of Oral Health Disparities that adversely affect vulnerable populations and the addressing of social drivers of health.

Other Healthcare Coverage (OHC) means dental coverage from another entity that is responsible for all or part of the payment for a Member's dental services. OHC may result from a health insurance policy or other contractual agreement or legal obligation to pay for health care services provided to a Member, 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 until all activities required during the Phaseout Period for each Service Area are fully completed to the satisfaction of DHCS, in its sole discretion.

Physician Services means professional services performed by dentists, including surgery, consultation, and home, office, and institutional calls.

Post-Payment Recovery means Contractor's efforts to recover the cost of the services from other third-party payers responsible for the payment of a Member's health care services.

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 Member 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.

Prepaid Ambulatory Health Plan (PAHP) means an entity that:

A. 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.
B. 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
C. 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:

A. 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.
B. Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and,
C. Does not have a comprehensive risk contract.

Preventive Services means dental care designed to prevent dental disease and/or its consequences.

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 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 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.

Proposer means the legal entity that is submitting the proposal and does not include affiliates.

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 Network means Primary Care Dentists, specialists, facilities, dental groups, subcontractors (including FQHC, RHC, and IHCP), subcontractors, and any other Providers that have a Network Provider Agreement with Contractor for the delivery of Medi-Cal covered 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 and Oral Health Access Transformation Program (QIOHATP) 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 dental services for individuals and populations increase the likelihood of desired dental outcomes and are consistent with current professional knowledge.

Quality Indicators/Quality Measures/Quality Metrics/Performance Measures means measurable variables relating to a specific clinic or dental 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.

Rating Period means a period selected by DHCS for which actuarially sound capitation rates are developed and documented in the rate certification submitted to CMS as required by 42 CFR section 438.7(a).

Risk Contract means a contract between the State an MCO, PIHP or PAHP under which the contractor:

A. Assumes risk for the cost of the services covered under the contract; and
B. Incurs loss if the cost of furnishing the services exceeds the payments under the contract.

Risk Sharing Mechanism means any payment arrangement, such as reinsurance, risk corridors, or stop-loss limits, documented in the CMS approved rate certification documents for the applicable Rating Period prior to the start of the Rating Period, that is developed in accordance with 42 CFR section 438.4, the rate development standards in 42 CFR section 438.5, and generally accepted actuarial principles and practices.

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 Section 1381 et. seq.

Service Area means the county or counties that Contractor is approved to operate in under the terms of this Contract. A Service Area may be limited to designated zip codes (under the U.S. Postal Service) within a county.

Service Location means the location where a Member obtains Covered Services 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 Department of Health Care Services (DHCS)., the single State agency as specified in 42 CFR 431.10.

State Work Days means any day that the Contractor and/or State is open for business.

Subcontract means a written agreement entered into by 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 Contractor specifically related to fulfilling 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.

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.

Working Capital Ratio means a liquidity ratio, calculated as current asset divided by current liabilities, that measures Contractor's ability to pay its current liabilities with current assets. Working Capital Ratio is computed in accordance with Generally Accepted Accounting Principles (GAAP).

EXHIBIT E2: DUTIES OF THE STATE

1. PAYMENT FOR SERVICES

Pursuant to EXHIBIT B: BUDGET DETAIL & PAYMENT PROVISIONS, DHCS shall pay to the Contractor capitation payments for each eligible Member under this contract.

2. 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.

3. ENROLLMENT

The purpose of DHCS' Medi-Cal Dental Managed Care system is to improve quality and access to care for Medi-Cal beneficiaries. For the purpose of this contract, 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 SECTION 4. ENROLLMENT AND DISENROLLMENT PROCESSING. DHCS agrees that to accomplish this goal it is necessary to be reasonably flexible with regard to the enrollment process.

4. ENROLLMENT AND DISENROLLMENT PROCESSING

4.1. 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.

4.2. ENROLLMENT COMPETITION

Notwithstanding any provision in this contract or law, DHCS shall ensure the following:

a. Eligible Beneficiaries have a choice of competing dental plans in the Sacramento Geographic Managed Care program.
b. Eligible Beneficiaries have a choice of competing dental plans in the Prepaid Health Plan program as well as the fee-for-service 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.

4.3. DISENROLLMENT PROCESSING

DHCS, or its Enrollment Contractor, shall review and process requests for disenrollment and notify the Contractor and the Member of its decision.

5. APPROVAL PROCESS FOR SUBMITTED MATERIALS DURING OPERATIONS

For materials required to be submitted during the Operations Period of this contract, DHCS shall make all reasonable efforts to review such materials within 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 SECTION 1. NETWORK CAPACITY.

6. RISK LIMITATION

Except as provided in EXHIBIT B: BUDGET DETAIL & PAYMENT PROVISIONS, 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.

7. MEMBER NOTIFICATION

DHCS shall notify Members of their dental care benefits and options available upon termination or expiration of this contract.

EXHIBIT E3: CONTRACTOR'S PARENT GUARANTY REQUIREMENTS

If Contractor is a subsidiary of a corporation or other legal entity, the full and prompt performance of all covenants, provisions, and agreements resulting from this Contract for the life of the Contract must be guaranteed by that entity in Contractor's chain of ownership, which is publicly traded (the "Guaranty"). This entity will be known as Contractor's "parent corporation" for purposes of the Contract.

A. The Guaranty must, at a minimum, meet the following requirements. It must:
    1. Be made to DHCS, in writing, by the Contract effective date;
    2. Be signed by an official authorized to bind the guarantor organization;
    3. Accept unconditional responsibility for all performance and financial requirements and obligations of the Contract including, but not limited to, maintenance of Tangible Net Equity and payment of liquidated damages;
    4. Recite that "for good and valuable consideration, receipt of which is hereby acknowledged," Guarantor is making the Guaranty;
    5. State that Guarantor stipulates that if the Contract is ultimately awarded to the subsidiary, that DHCS will so award in reliance upon the Guaranty;
    6. State that the undersigned Corporate Officer warrants that they have personally reviewed all pertinent corporate documents, including but not limited to, articles of incorporation, bylaws, and agreements between the parent and subsidiary; and
    7. State that the undersigned Corporate Officer warrants that nothing in these documents in any way limits the capacity of the parent to enter into the instant Contract of Guaranty.

B. The Guaranty must include the following Provisions:
    1. DHCS need not take any action against Contractor, any other guarantor, or any other person, firm or corporation, or resort to any security held by Contractor at any time before proceeding against Guarantor;
    2. Guarantor hereby waives any and all notices and demands which may be required to be given by any other statute or rule of law and agrees that its liability hereunder will be in no way affected, diminished, or released by any extension of time, forbearance, or waiver, which may be granted to Contractor, its successor or assignee.
    3. This Guaranty will extend to and include all future amendments, modifications, and extensions of the Contract and all future supplemental and other agreements with respect to matters covered by the Contract that DHCS and Contractor may enter into, with or without notice to or knowledge of Guarantor, but Guarantor will have the benefit of any such extension, forbearance, waiver, amendment, modification, or supplemental or other agreement. It is the purpose and intent of the parties hereto that the obligations

of Guarantor hereunder will be co-extensive with, but not in excess of, the obligations of Contractor, its successor or assignee, under the Contract; and

4. Guarantor agrees that the Guaranty will continue in full force and effect despite any change in the legal or corporate status of the subsidiary, including, but not limited to, its sale, reorganization, dissolution or bankruptcy.

C. The Guaranty must be presented in terms, which DHCS in its sole discretion, determines, as a whole, adequately establish Contractor's financial responsibility.

Instructions to Contractor:

Final Invoice(s)

Submit one original invoice signed by a person authorized to bind the Contractor. The original invoice may submitted and signed electronically using an authorized electronic signature in accordance with California State Administrative Manual 1240. The only authorized form of electronic signature is a digital signature that meets requirements under California Government Code 16.5 and California Secretary of State Regulations for Digital 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: _____

Printed Name/Title of Person Signing: _____

Date: _____

Distribution: Accounting (Original) Program

Business Associate Addendum

1. This Agreement has been determined to constitute a business associate relationship under the Health Insurance Portability and Accountability Act (HIPAA) and its implementing privacy and security regulations at 45 Code of Federal Regulations, Parts 160 and 164 (collectively, and as used in this Agreement)

2. The term “Agreement” as used in this document refers to and includes both this Business Associate Addendum and the contract to which this Business Associate Agreement is attached as an exhibit, if any.

3. For purposes of this Agreement, the term “Business Associate” shall have the same meaning as set forth in 45 CFR section 160.103.

4. The Department of Health Care Services (DHCS) intends that Business Associate may create, receive, maintain, transmit or aggregate certain information pursuant to the terms of this Agreement, some of which information may constitute Protected Health Information (PHI) and/or confidential information protected by Federal and/or state laws.

   4.1 As used in this Agreement and unless otherwise stated, the term “PHI” refers to and includes both “PHI” as defined at 45 CFR section 160.103 and Personal Information (PI) as defined in the Information Practices Act (IPA) at California Civil Code section 1798.3(a). PHI includes information in any form, including paper, oral, and electronic.

   4.2 As used in this Agreement, the term “confidential information” refers to information not otherwise defined as PHI in Section 4.1 of this Agreement, but to which state and/or federal privacy and/or security protections apply.

5. Contractor (however named elsewhere in this Agreement) is the Business Associate of DHCS acting on DHCS's behalf and provides services or arranges, performs or assists in the performance of functions or activities on behalf of DHCS, and may create, receive, maintain, transmit, aggregate, use or disclose PHI (collectively, “use or disclose PHI”) in order to fulfill Business Associate’s obligations under this Agreement. DHCS and Business Associate are each a party to this Agreement and are collectively referred to as the "parties.”

6. The terms used in this Agreement, but not otherwise defined, shall have the same meanings as those terms in HIPAA and/or the IPA. Any reference to statutory or regulatory language shall be to such language as in effect or as amended.

7. **Permitted Uses and Disclosures of PHI by Business Associate**. Except as otherwise indicated in this Agreement, Business Associate may use or disclose PHI, inclusive of de-identified data derived from such PHI, only to perform functions, activities or services specified in this Agreement on behalf of DHCS, provided that such use or disclosure would not violate HIPAA or other applicable laws if done by DHCS.

   7.1 Specific Use and Disclosure Provisions. Except as otherwise indicated in this Agreement, Business Associate may use and disclose PHI if necessary for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate. Business Associate may disclose PHI for this purpose if the disclosure is required by law, or the Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person. The person shall

notify the Business Associate of any instances of which the person is aware that the confidentiality of the information has been breached, unless such person is a treatment provider not acting as a business associate of Business Associate.

7.2 **Nondisclosure.** Business Associate shall not use or disclose PHI or other confidential information other than as permitted or required by this Agreement or as required by law.

8. Compliance with Other Applicable Law

8.1 To the extent that other state and/or federal laws provide additional, stricter and/or more protective (collectively, more protective) privacy and/or security protections to PHI or other confidential information covered under this Agreement beyond those provided through HIPAA, Business Associate agrees:

8.1.1 To comply with the more protective of the privacy and security standards set forth in applicable state or federal laws to the extent such standards provide a greater degree of protection and security than HIPAA or are otherwise more favorable to the individuals whose information is concerned; and

8.1.2 To treat any violation of such additional and/or more protective standards as a breach or security incident, as appropriate, pursuant to Section 19. of this Agreement.

8.2 Examples of laws that provide additional and/or stricter privacy protections to certain types of PHI and/or confidential information, as defined in Section 4. of this Agreement, include, but are not limited to the Information Practices Act, California Civil Code sections 1798-1798.78, Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, Welfare and Institutions Code section 5328, and California Health and Safety Code section 11845.5.

8.3 If Business Associate is a Qualified Service Organization (QSO) as defined in 42 CFR section 2.11, Business Associate agrees to be bound by and comply with subdivisions (2)(i) and (2)(ii) under the definition of QSO in 42 CFR section 2.11.

9. Additional Responsibilities of Business Associate

9.1 Safeguards and Security.

9.1.1 Business Associate shall use safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI and other confidential data and comply, where applicable, with subpart C of 45 CFR Part 164 with respect to electronic protected health information, to prevent use or disclosure of the information other than as provided for by this Agreement. Such safeguards shall be based on applicable Federal Information Processing Standards (FIPS) Publication 199 protection levels.

9.1.2 Business Associate shall, at a minimum, utilize a National Institute of Standards and Technology Special Publication (NIST SP) 800-53 compliant security framework when selecting and implementing its security controls and shall maintain continuous compliance with NIST SP 800- 53 as it may be updated from time to time. The current version of NIST SP 800-53, Revision 5, is available online at https://csrc.nist.gov/pubs/sp/800/53/r5/upd1/final; updates will be available online at https://csrc.nist.gov/publications/sp800.

9.1.3 Business Associate shall employ FIPS 140-3 validated encryption of PHI at rest and in motion unless Business Associate determines it is not reasonable and appropriate to do

so based upon a risk assessment, and equivalent alternative measures are in place and documented as such. FIPS 140-3 validation can be determined online at https://csrc.nist.gov/projects/cryptographic-module-validation-program/validated-modules/search. In addition, Business Associate shall maintain, at a minimum, the most current industry standards for transmission and storage of PHI and other confidential information.

9.1.4 Business Associate shall apply security patches and upgrades, and keep virus software up-to- date, on all systems on which PHI and other confidential information may be used.

9.1.5 Business Associate shall ensure that all members of its workforce with access to PHI and/or other confidential information sign a confidentiality statement prior to access to such data. The statement must be renewed annually.

9.1.6 Business Associate shall identify the security official who is responsible for the development and implementation of the policies and procedures required by 45 CFR Part 164, Subpart C.

9.1.7 Remote access to PHI from outside the continental United States, inclusive of remote access to PHI by Business Associate's support staff in identified support centers, is prohibited.

9.1.8 Business Associate shall only store PHI in a data center physically located within the continental United States.

9.2 Business Associate's Agent. Business Associate shall ensure that any agents, subcontractors, subawardees, vendors or others (collectively, "agents") that use or disclose PHI and/or confidential information on behalf of Business Associate agree to the same restrictions and conditions that apply to Business Associate with respect to such PHI and/or confidential information.

10. **Mitigation of Harmful Effects**. Business Associate shall mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI and other confidential information in violation of the requirements of this Agreement.

11. **Access to PHI.** Business Associate shall make PHI available in accordance with 45 CFR section 164.524.

12. **Amendment of PHI.** Business Associate shall make PHI available for amendment and incorporate any amendments to protected health information in accordance with 45 CFR section 164.526.

13. **Accounting for Disclosures.** Business Associate shall make available the information required to provide an accounting of disclosures in accordance with 45 CFR section 164.528.

14. **Collaboration.** The parties shall collaborate as appropriate and necessary to ensure compliance with this Agreement, including but not limited to Sections 11 – 13 of this Agreement. The parties acknowledge and agree that neither party intends that this Agreement shall create obligations and/or liabilities that do not otherwise exist as appropriate based on the nature of the work performed and applicable law.

15. **Compliance with DHCS Obligations.** To the extent Business Associate is to carry out an obligation of DHCS under 45 CFR Part 164, Subpart E, comply with the requirements of the subpart that apply to DHCS in the performance of such obligation.

16. **Access to Practices, Books and Records.** Business Associate shall make its internal practices, books, and records relating to the use and disclosure of PHI on behalf of DHCS available to the federal Secretary of Health and Human Services for purposes of determining DHCS' compliance with 45 CFR Part 164, Subpart E.

17. **Return or Destroy PHI on Termination; Survival.** At termination of this Agreement, if feasible, Business Associate shall return or destroy all PHI and other confidential information received from, or created or received by Business Associate on behalf of, DHCS that Business Associate still maintains in any form and retain no copies of such information. 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. If such return or destruction is not feasible, Business Associate shall extend the protections of this Agreement to the information and limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

18. **Special Provision for SSA Data.** If Business Associate receives data from or on behalf of DHCS that was verified by or provided by the Social Security Administration (SSA data) and is subject to an agreement between DHCS and SSA, Business Associate shall provide, upon request by DHCS, a list of all employees and agents and employees who have access to such data, including employees and agents of its agents, to DHCS.

19. **Breaches and Security Incidents.** Business Associate shall implement reasonable systems for the discovery and prompt reporting of any breach or security incident, and take the following steps:

19.1 Notice to DHCS.

19.1.1 Business Associate shall notify DHCS **immediately** upon the discovery of a suspected breach or security incident that involves SSA data. This notification shall be provided via the DHCS Incident Reporting Portal upon discovery of the breach. If Business Associate is unable to provide notification via the DHCS Incident Reporting Portal, then Business Associate shall provide notice by email or telephone to DHCS.

19.1.2 Business Associate shall notify DHCS **within 24** hours via the online DHCS Incident Reporting Portal (or by email or telephone if Business Associate is unable to use the DHCS Incident Reporting Portal) of the discovery of the following, unless attributable to a treatment provider that is not acting as a business associate of Business Associate:

19.1.2.1 Unsecured PHI if the PHI is reasonably believed to have been accessed or acquired by an unauthorized person;

19.1.2.2 Any suspected security incident which risks unauthorized access to PHI and/or other confidential information;

19.1.2.3 Any intrusion or unauthorized access, use or disclosure of PHI in violation of this Agreement; or

19.1.2.4 Potential loss of confidential information affecting this Agreement.

19.1.3 Notice submitted to the DHCS Incident Reporting Portal will be sent to the DHCS Program Contract Manager (as applicable), the DHCS Privacy Office, and the DHCS Information Security Office. If providing notice to DHCS via email, use the DHCS contact information at Section 19.6 below (collectively, "DHCS Contacts").

Notice shall be made using the DHCS Incident Reporting Portal via the link on the DHCS Data Privacy Website online at

https://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/default.aspx

Notice via email shall be made using the current DHCS "Privacy Incident Reporting Form" and shall include all information known at the time the incident is reported. The form is available online at

https://www.dhcs.ca.gov/formsandpubs/laws/priv/Documents/Privacy-Incident-Report-PIR.pdf

Upon discovery of a breach or suspected security incident, intrusion or unauthorized access, use or disclosure of PHI, Business Associate shall take:

19.1.3.1 Prompt action to mitigate any risks or damages involved with the security incident or breach; and

19.1.3.2 Any action pertaining to such unauthorized disclosure required by applicable Federal and State law.

19.2 Investigation. Business Associate shall immediately investigate such security incident or breach.

19.3 Complete Report. Business Associate shall provide a complete report of the investigation to DHCS within ten (10) working days of the discovery of the security incident or breach. This complete report must include any applicable additional information not included in the initial submission. The complete report shall include an assessment of all known factors relevant to a determination of whether a breach occurred under HIPAA and other applicable federal and state laws. The report shall also include a full, detailed corrective action plan, including its implementation date and information on mitigation measures taken to halt and/or contain the improper use or disclosure. If DHCS requests additional information, Business Associate shall make reasonable efforts to provide DHCS with such information. DHCS will review and approve or disapprove Business Associate's determination of whether a breach occurred, whether the security incident or breach is reportable to the appropriate entities, if individual notifications are required, and Business Associate's corrective action plan.

19.3.1 If Business Associate does not submit a complete report within the ten (10) working day timeframe, Business Associate shall request approval from DHCS within the ten (10) working day timeframe of a new submission timeframe for the complete report.

19.4 Notification of Individuals. If the cause of a breach is attributable to Business Associate or its agents, other than when attributable to a treatment provider that is not acting as a business associate of Business Associate, Business Associate shall notify individuals accordingly and shall pay all costs of such notifications, as well as all costs associated with the breach. The

notifications shall comply with applicable federal and state law. DHCS shall approve the time, manner and content of any such notifications and their review and approval must be obtained before the notifications are made.

19.5 Responsibility for Reporting of Breaches to Entities Other than DHCS. If the cause of a breach of PHI is attributable to Business Associate or its agents, other than when attributable to a treatment provider that is not acting as a business associate of Business Associate, Business Associate is responsible for all required reporting of the breach as required by applicable federal and state law.

19.6 DHCS Contact Information. To contact the above referenced DHCS staff, the Contractor shall initiate contact as indicated here. DHCS reserves the right to make changes to the contact information below by giving written notice to Business Associate. These changes shall not require an amendment to this Agreement.

DHCS Program Contract Manager	**DHCS Privacy Office**	**DHCS Information Security Office**
See the Scope of Work exhibit for Program Contract Manager information. If this Business Associate Agreement is not attached as an exhibit to a contract, contact the DHCS signatory to this Agreement.	Privacy Office c/o: Data Privacy Unit Department of Health Care Services P.O. Box 997413, MS 4722 Sacramento, CA 95899- 7413 Email: incidents@dhcs.ca.gov Telephone: (916) 445- 4646	Information Security Office Department of Health Care Services P.O. Box 997413, MS 6400 Sacramento, CA 95899-7413 Email: incidents@dhcs.ca.gov

20. Responsibility of DHCS. DHCS agrees to not request the Business Associate to use or disclose PHI in any manner that would not be permissible under HIPAA and/or other applicable federal and/or state law.

21. Audits, Inspection and Enforcement

21.1 From time to time, DHCS may inspect the facilities, systems, books and records of Business Associate to monitor compliance with this Agreement. Business Associate shall promptly remedy any violation of this Agreement and shall certify the same to the DHCS Privacy Officer in writing. Whether or how

DHCS exercises this provision shall not in any respect relieve Business Associate of its responsibility to comply with this Agreement.

21.2 If Business Associate is the subject of an audit, compliance review, investigation or any proceeding that is related to the performance of its obligations pursuant to this Agreement, or is the subject of any judicial or administrative proceeding alleging a violation of HIPAA, Business Associate shall promptly notify DHCS unless it is legally prohibited from doing so.

22. Termination

22.1 Termination for Cause. Upon DHCS' knowledge of a violation of this Agreement by Business Associate, DHCS may in its discretion:

22.1.1 Provide an opportunity for Business Associate to cure the violation and terminate this Agreement if Business Associate does not do so within the time specified by DHCS; or

22.1.2 Terminate this Agreement if Business Associate has violated a material term of this Agreement.

22.2 Judicial or Administrative Proceedings. DHCS may terminate this Agreement if Business Associate is found to have violated HIPAA, or stipulates or consents to any such conclusion, in any judicial or administrative proceeding.

23. Miscellaneous Provisions

23.1 Disclaimer. DHCS makes no warranty or representation that compliance by Business Associate with this Agreement will satisfy Business Associate's business needs or compliance obligations. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI and other confidential information.

23.2. Amendment.

23.2.1 Any provision of this Agreement which is in conflict with current or future applicable Federal or State laws is hereby amended to conform to the provisions of those laws. Such amendment of this Agreement shall be effective on the effective date of the laws 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.

23.2.2 Failure by Business Associate to take necessary actions required by amendments to this Agreement under Section 23.2.1 shall constitute a material violation of this Agreement.

23.3 Assistance in Litigation or Administrative Proceedings. Business Associate shall make itself and its employees and agents 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 and/or employees based upon claimed violation of HIPAA, which involve inactions or actions by the Business Associate.

23.4 No Third-Party Beneficiaries. Nothing in this Agreement is intended to or shall confer, upon any third person any rights or remedies whatsoever.

23.5 Interpretation. The terms and conditions in this Agreement shall be interpreted as broadly as necessary to implement and comply with HIPAA and other applicable laws.

23.6 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.