

DEPARTMENT OF HEALTH SERVICES

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September 13, 2000

MMCD All Plan Letter 00010

T O : ALL MEDI-CAL MANAGED CARE PLANS

SUBJECT: DRAFT 2000 MEDI-CAL MANAGED CARE CONTRACT AMENDMENTS
 Package 00-01

The purpose of this letter is to submit draft 2000 Medi-Cal managed care plan contract amendment language relating to recent changes in policy, law, or regulation to all **Medi-Cal** managed care plan contractors for review and comment. Some of the proposed amendments are the result of specific requests by various plans. Other amendments incorporate suggestions from the various work groups convened by the **Office** of Clinical Standards and Quality.

The following is a summary of each proposed contract amendment by subject area. The table beneath the subject heading of each draft amendment summary indicates which plan contract(s) will be affected by the proposed language. Unless otherwise specified, the enclosed draft amendment language is based on the Two-Plan Model contract boilerplate.

EXHIBIT 1 - DEFINITION OF CONTRACTING OFFICER AND CONTRACTOR'S REPRESENTATIVE

COHS	2-PLAN	GMC	HSD	PHP	PCCM	SP	FFMC
X	X	X	X	X	X	X	X

Adds language defining the terms "Contracting Officer" and "Contractor's Representative."

EXHIBITS 2 AND 10 - DUAL PARTICIPATION IN THE MULTIPURPOSE SENIOR SERVICES PROGRAM (MSSP) AND MEDI-CAL MANAGED CARE .

COHS	2-PLAN	GMC	HSD	PHP	PCCM	SP	FFMC
	X			X	X	X	X



Amends language similar to that already incorporated in County Organized Health System (COHS), Geographic Managed Care (GMC), and the Healthy San Diego (HSD) contracts to reflect a change in departmental policy regarding the concurrent participation of enrollees in the MSSP and Medi-Cal managed care. This change is being made at the request of several participating health plans.

EXHIBIT 3 – LOCAL INITIATIVE CONTRACT EXTENSION

COHS	2-PLAN	GMC	HSD	PHP	PCCM	SP	FFMC
	X						

Adds language similar to that already incorporated in COHS contracts that gives the Department the option to extend the term of local initiative contracts by invoking up to three separate extensions of one year each. This provision will be implemented as a separate amendment from others included in this letter to assure timely processing by each affected plan.

EXHIBIT 4 - CAPITATION WITHOLD SANCTION

COHS	2-PLAN	GMC	HSD	PHP	PCCM	SP	FFMC
	X			X	X		

Adds language similar to that already incorporated in COHS contracts to specify the penalty that may be applied for contract violations as determined by the Department.

EXHIBIT 5 - MINORITY/WOMEN/DISABLED VETERAN BUSINESS ENTERPRISES

COHS	2-PLAN	GMC	HSD	PHP	PCCM	SP	FFMC
	X			X	X	X	X

Deletes language related to Minority and Women Owned Business Enterprises pursuant to the federal appellate court decision effective March 10, 1998, that declared Public Contract Code Section 10115 to be unconstitutional. This decision does not effect the Disabled Veteran Business Enterprise Participation Program.

Amendments to COHS, GMC, and the HSD contracts have already been executed.

EXHIBIT 6 - RECORDS RECOVERY FOR LITIGATION

COHS	2-PLAN	GMC	HSD	PHP	PCCM	SP	FFMC
X	X	X	X	X	X	X	X

Deletes language specific to the Tobacco Lawsuit since the lawsuit has been settled. Adds language providing a general reference to records related to recovery for litigation.

Amendments to COHS contracts, with the exception of the Santa Barbara Health Initiative contract, have already been executed.

EXHIBIT 7 - CHILD SUPPORT COMPLIANCE ACT ACKNOWLEDGEMENT

COHS	2-PLAN	GMC	HSD	PHP	PCCM	SP	FFMC
X	X	X	X	X	X	X	X

Adds language to reflect requirements of AB 1396 (Chapter 899, Statutes of 1998) that all contracts in excess of \$100,000 contain a certification made by the contractor acknowledging the importance of child support obligations and an agreement to comply with all applicable laws relating to child and family support enforcement.

EXHIBIT 8 - NON-PHYSICIAN MEDICAL PRACTITIONERS

COHS	2-PLAN	GMC	HSD	PHP	PCCM	SP	FFMC
X	X		X	X	X	X	X

Adds language clarifying access requirements for Primary Care Physicians and Non-Physician Medical Practitioners serving as Primary Care Physicians. Adds language specifying that members selecting a Non-Physician Medical Practitioner as a Primary Care Physician must also be assigned a supervising Primary Care Physician. The term "Non-Physician Medical Practitioner" is substituted for the previously used terms "nurse practitioner" and "certified nurse midwife."

Similar language is already incorporated in GMC contracts.

EXHIBITS 2 AND 9 - MAJOR ORGAN TRANSPLANTS

COHS	2-PLAN	GMC	HSD	PHP	PCCM	SP	FFMC
X	X	X	X	X	X	X	X

Amends language to clarify that, except for kidney transplants, any major organ transplant approved as a Medi-Cal benefit is not covered under the contract.

Similar language has already been incorporated in COHS, GMC, and the HSD contracts.

EXHIBIT 1 1 - ALCOHOL AND DRUG TREATMENT SERVICES

COHS	2-PLAN	GMC	HSD	PHP	PCCM	SP	FFMC
X	X	X	X	X	X	X	X

Language is amended to reference Medi-Cal covered alcohol and drug treatment services as "Drug Medi-Cal substance abuse services" consistent with Title 22, California Code of Regulations Section 51341.1.

EXHIBIT 12 - COVERED SERVICES

COHS	2-PLAN	GMC	HSD	PHP	PCCM	SP	FFMC
	X	X	X	X	X	X	X

Excluded Drugs

Adds language referencing excluded drugs for the treatment of human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) in a manner consistent with the reference to excluded psychotherapeutic drugs. Attachment II is amended to update the list of excluded HIV and AIDS drugs, and Attachment III is amended to update the list of excluded psychotherapeutic drugs.

Amendments to COHS contracts have already been executed.

EXHIBIT 13 - 1998 KNOX-KEENE DISCLOSURE REQUIREMENTS

COHS	2-PLAN	GMC	HSD	PHP	PCCM	SP	FFMC
X	X	X	X	X	X	X	X

Adds language to reflect 1998 disclosure requirements regarding evidence of coverage

(EOC) and disclosure forms for Knox-Keene licensed health care service plans (HCSP) and makes them applicable to all plan contracts.

- AB 1225 (Chapter 457, Statutes of 1998) requires HCSPs to notify members of the positive benefits of organ donation and how to become an organ or tissue donor.
- SB 750 (Chapter 835, Statutes of 1998) requires HCSPs to include a notice in the EOC if financial incentives or bonuses are used with plan providers, and to specify that members can request additional information about provider incentives from the plan, a provider, or a provider group.
- AB 974 (Chapter 68, Statutes of 1998) requires HCSPs to disclose if the plan uses a drug formulary, including what a formulary is, how the plan decides to include or exclude drugs from the formulary, and how often the formulary is updated. Members must also be informed that they can request specific information about whether a drug is on the plan's formulary and the telephone number for requesting this information.

EXHIBIT 14 - CONTINUITY OF CARE AND CASE MANAGEMENT

COHS	2-PLAN	GMC	HSD	PHP	PCCM	SP	FFMC
X					X		

To minimize significant differences between managed care models operating in adjacent geographic areas, language is added to COHS and Primary Care Case Management (PCCM) contracts regarding standing referrals to a specialist or specialty care center and continuation of care with a terminated provider. This amendment conforms COHS and PCCM contracts to requirements of Senate Bill (SB) 1129 Chapter 180, Statutes of 1998) and Assembly Bill (AB) 1181 (Chapter 31, Statutes of 1998) which apply to Knox-Keene licensed HCSPs.

SB 1129 provides for continuation of care in cases where a course of treatment is in progress when an enrollee's provider is terminated from a plan's network. AB 1181 requires plans to establish a process by which an enrollee may obtain a standing referral to a specialty care physician, clinic, or care center. This amendment will assure that high quality care is easily available to all Medi-Cal managed care plan enrollees without unnecessary barriers or impediments.

Language regarding initial health assessments is added to specify that an initial health assessment may be required in fewer than 120 days following enrollment for members for whom the American Academy of Pediatrics' recommended periodic health assessment applies.

EXHIBIT 15 – CLINICAL STANDARDS AND QUALITY IMPROVEMENT

COHS	2-PLAN	GMC	HSD	PHP	PCCM	SP	FFMC
X	X	X	X	X	X		

Amends the definition of HEDIS Compliance Audit and adds new definitions.

Amends Section 3.19 Sanctions and 4.9 in commercial and local initiative contracts to correct errors- in regulatory language.

Amends various Sections of Article VI, SCOPE OF WORK, to change requirements relative to Cultural and Linguistic Services and Quality Improvement Projects, including a new requirement that the Plan validate that their encounter level data is complete and accurate prior to its submission to DHS. Some of the changes in these sections reflect requests made by the plans’ representatives participating in various work groups.

Exhibit 16 – SUBMISSION OF PLAN POLICIES, PROTOCOLS AND PROCEDURES

COHS	2-PLAN	GMC	HSD	PHP	PCCM	SP	FFMC
X	X	X	X	X	X		

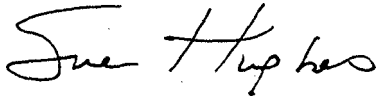
The requirement for routine submission of all policies, procedures, and protocols, including all revisions thereto, is deleted. The Plan is instead required to have these documents available for review at the Plan’s offices and to provide copies of specific policies, procedures, or protocols upon request. Definitions for these documents are added to Article II, General Terms and Conditions, Definitions.

A requirement is added that plans are responsible to assure that the providers within their network are sufficiently trained to implement changes to plan protocols and procedures in a timely manner.

Also enclosed is a summary of the meeting held with plans on May 23, 2000, at which’ time, many of the amendments in this letter were introduced in conceptual terms. The summary also identifies those suggestions that were incorporated into this amendment package.

Your comments on the enclosed exhibits would be appreciated within 30 days of receipt of this letter. If you have questions about the enclosed draft amendments or the

enclosed summary of the May 23, 2000 meeting, please contact your contract manager. Your perspective regarding operational issues relative to these amendments would be of particular interest.



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Enclosure

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**Contract Amendment Concepts
Meeting Summary
May 23, 2000**

OUTSTANDING ISSUES

Concerning the selection of specific HEDIS measures (related to the data reporting performance measures linked to an incentives plan):

- Are these the “right” ones and will DHS consider other choices?
Certain innovative practices, such as the use of telemedicine or telephone triage services, are penalized by some of the measures.)
- Withholds are penalties and “true bonuses are not monies collected from many to redistribute to a few.”
- After DHS considers the objections, will the decision to move forward (global concept of using these measures to “reward”) be reexamined?
- The use of the mean appears invalid -will DHS reconsider its use?
- FFS performance was identified as an alternative standard for comparisons of plan performance.
- The use of “contest rules” is objectionable to some and reconsideration of “minimum standards” is requested. *(Many plans felt they could predict the five “winners” without difficulty.)*

Many participants felt that a basic flaw in this concept is that statistically insignificant differences in plan performance would result in “reward” for some and “penalty” for others.

Performance incentive revisions are planned with the next amendment package.

Concerning beneficiaries that need major organ transplants, a policy letter is requested:

- Issues of disenrollment
- CCS coordination for children
- Enrollment of a stable patient after the transplant is completed and the patient is considered stable.

Of critical concern is the appropriate time period following transplant that should elapse prior to enrollment in a health plan and assurances that the appropriate level of service is anticipated by the capitation payments (expensive drugs, more frequent office visits, more aggressive immunization for seasonal influenza, etc.)

DHS agrees to issue a policy letter.

**Contract Amendment Concepts
Meeting Summary
May 23, 2000**

Concerning the drugs that are carved out of the contracts, will DHS consider changing the contract attachment to list the drugs by class, rather than by name, as is currently done? Because there is a lag between the introduction of a new drug and the amendments to the contract, is it a contract violation when the pharmacy successfully bills FFS Medi-Cal for a new drug that is not explicitly carved out?

DHS needs to conduct further research on this subject.

Concerning the issues of extension versus other options for the expiring local initiative contracts, will DHS reduce the notice period for some plans?

- CPs and LIs would prefer a separate extension amendment (single purpose amendment).
- There was general support to treat LIs and CPs the same regarding extensions of the contract.
- DHS was asked to consider alternatives to the three one-year extensions that have been proposed for the LIs.

DHS agrees to place the necessary language into the current amendment package for plans to review. DHS agrees to take any other actions necessary to implement appropriate extensions.

A request was made for clarification concerning the frequency of a group cultural and linguistics needs assessment requirement. The opinion was expressed that the current contract and the policy letter may not agree.

DHS research into this issue resulted in a finding that each contract type may have a different interpretation. The current amendment package contains language addressing this concern.

AMENDMENTS REQUESTED BY PARTICIPANTS

Require CMAC to reopen rate negotiations to “pass-through” rate changes that were not specifically anticipated in the rate development process.

Alternatively, implement annual rates adjustments:

Enclosure 1

Contract Amendment Concepts Meeting Summary May 23, 2000

- Renegotiate GMC contract rates annually to eliminate the “pass-through” issues and improve general understanding of the rate methodology.
- Require CMAC to negotiate annual rates for COHS contracts that reflect “pass-through” of Medi-Cal rate changes.

This is not within our control, negotiations with CMAC will be necessary.

Utilize “reasonable” standards for data reporting (related to the first of the Outstanding Issues in this Meeting Summary).

No specific response is possible at this time; further research will be necessary concerning the meaning of the term “reasonable standard” requested by the participant.

Eliminate the CCS carve out (strong support from all present) to:

- Reduce confusion for parents and providers
- Centralize and streamline coordination
- Avoid delays in payment to providers
- Increase provider participation in CCS
- Eliminate the delays in access associated with determining program eligibility
- Eliminate the confusion for plans and their subcontractors regarding coverage liability when a family refuses to participate in CCS for an eligible diagnosis.
- A legislative change will be required to permit carve-in.
- CCS processing of paneling applications must be faster. (It still takes years.)

This concept will be presented to Children’s Medical Services for comment. This suggestion will require Legislation to accomplish.

Institute lock-in of enrollment for 12 months. (mixed opinions in the group)

Related issues included:

- 12 months guaranteed eligibility
- A default algorithm that assigns “returnees” that had been disenrolled due to a break in eligibility differently (returns them to their most recent previous plan of enrollment if there is less than a 3 month break in eligibility).

Enclosure 1

Contract Amendment Concepts Meeting Summary May 23, 2000

- A lock-in designed to limit “plan hopping” in Sacramento and San Diego Counties only.

DHS will place this on hold for an unspecified time. The requirements for beneficiaries to file quarterly reports were changed this year and as a result, it is expected that fewer interruptions in eligibility may occur, making enrollment lock-in less desirable.

Clarify the circumstances appropriate for application of the Change Order provisions in Section 3.33.

(Y2K issues and the addition of aid codes were cited as problematic applications in the recent past.)

DHS will research future applications of Change Orders.

Expand the ability of the plan to claim the “AIDS rate” to capture the whole population used to calculate the different rate.

(It was the belief of the requester that persons that are HIV positive and included in the population used to calculate the rate. Therefore, the plan should be allowed to claim the higher rate for HIV positive persons in addition to those persons that meet the current contractual criteria for an AIDS rate.)

Upon investigation, it was verified that the “AIDS rate” is calculated using a population that meets the current contractual criteria for claiming the rate. No further action is planned at this time.

Limit retroactive disenrollment to a specific length of time (60 days, 3 calendar months, 6 calendar months).

(Plans complained that they may have already paid claims for a member, only to have the person retroactively disenrolled and capifation recovered for the month in which the claims were paid.)

DHS needs to conduct more research into this issue.

Clarify how plans are to process claims for outpatient care in certain outpatient departments when the care is obtained out-of-plan.

Enclosure 1

Contract Amendment Concepts Meeting Summary May 23, 2000

(The problem of Los Angeles County's agreement with FFS Medi-Cal was cited as an example of confusion on the providers side. The requestor also stated that this issue might be resolved with an EDS bulletin that clearly stated the expectation that managed care plans receive an itemized bill in order to report contractually required encounter data.)

No response can be made at this time as more research is required.

Provisions concerning the payment of claims should be made consistent among all contracts. Discrepancies have been noted between GMC and 2 Plan Model commercial plan contracts.

This item has been resolved.

Because the production of an Evidence of Coverage (EOC) booklet is subject to tight cost controls, contract amendments that will require additions or deletions to this document should be combined in a single package and timed to coincide with Knox-Keene requirements for similar revisions.

DHS agrees to make an effort to implement this suggestion to the extent possible..

DEFINITION OF CONTRACTING OFFICER AND CONTRACTOR'S REPRESENTATIVE

In commercial plan and local initiative contracts, amend Article II, General Terms and Conditions, Definitions, by adding Y2., Contracting Officer, and Z2., Contractor's Representative as follows:

Y2. Contracting Officer means the single administrator of this Contract appointed by the Director of DHS. On behalf of DHS, the Contracting Officer will make all determinations and take all actions as are appropriate to implement this contract, subject to the limitations of the ~~under this Contract~~.

Z2. Contractor's Representative means the single administrator who is authorized to bind the Contractor on all matters related to this contract ~~designated by the Contractor to make all determinations and~~ take all actions as are necessary to implement Contractor's obligations, subject to the limitations ~~appropriate to implement this Contract, subject to the limitations of~~ the Contract.

DUAL PARTICIPATION IN THE MULTIPURPOSE SENIOR SERVICES PROGRAM (MSSP) AND MEDI-CAL MANAGED CARE

and

MAJOR ORGAN TRANSPLANTS

In commercial plan and local initiative contracts, amend Article II, Section CC, Subsection 2, Definitions as follows:

- CC.** **Eligible Beneficiary** means any Medi-Cal beneficiary who is residing in the Contractor's Service Area with one of the following aid codes: CalWORKs/Public Assistance Family - aid codes 30, 32, 33, 35, 38, 39, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 40, 42, 54, 59, 7X; Medically Needy Family - aid code 34; Public Assistance Aged - aid codes 10, 16, 18; Medically Needy Aged - aid code 14; Public Assistance Blind - aid codes 20, 26, 28, 6A; Medically Needy Blind - aid code 24; Public Assistance Disabled - aid codes 36, 60, 66, 68, 6C, 6N, 6P, 6R; Medically Needy Disabled - aid code 64; Medically Indigent Child - aid codes 03, 04, 4C, 4K, 5K, 45, 82; Medically Indigent Adult - aid code 86; and Refugees - aid codes 01, OA, 02, and 08, with the following exclusions:
1. Individuals who have been approved, by the Medi-Cal Field Office or the California Children Services Program for ~~bone marrow, heart, heart-lung, liver, lung, combined liver and kidney, or combined liver and small bowel transplants~~ any major organ transplant except kidney transplants.
 2. Individuals who elect and are accepted to participate in the following Medi-Cal waiver programs: In-Home Medical Care Waiver Program, the Skilled Nursing Facility Waiver Program, the Model Waiver Program, and the Acquired Immune Deficiency Syndrome (AIDS) and AIDS Related C o n d i t i o n s W a i v e r P r o g r a m * ~~Waiver program~~.

LOCAL INITIATIVE CONTRACT EXTENSION

In local initiative contracts, amend Article III, General Terms and Conditions, Section 3.14, Term, by adding Subsection 3.14.1, Contract Extension as follows:

3.14.1 Contract Extension

DHS will have the exclusive option to extend the term of the contract during the last twelve (12) months of the Contract, as determined by the original termination date or by a new termination date if an extension has been exercised. DHS may irivoke up to three (3) separate extensions of one (1) year each. The contractor will be given at least nine (9) months of prior written notice of DHS' decision on whether or not it will exercise this option to extend the contract.

The Contractor will notify DHS of its intent to accept or reject the extension within five (5) State working days of the receipt of the notice from DHS.

CAPITATION WITHHOLD SANCTION

In commercial plan contracts, amend Article III, General Terms and Conditions, Section 3.19, Sanctions, by adding Subsection 3.19.1, Capitation Withhold Sanction; and in local initiative contracts, amend Article III, General Terms and Conditions, Section 3.17, Sanctions, by adding Subsection 3.17.1, Capitation Withhold Sanction as follows:

3.19.1 Capitation Withhold Sanction

In addition to those sanctions set forth in Section 3. 17 {3.19} above, the following- actions may be taken, at the discretion of the Director, for contract violations as determined by the Director:

- A. Warn that future or continued contract violations will result in action stated in B of this paragraph;
- B. The Department may withhold a) up to one percent (1%) of the cavitation payment each month for up to six months if a violation is not corrected within the schedule agreed to by Contractor and the Department, and b) the part of the capitation payment eaul to the amount in dispute or claims not paid. Once the violation has been corrected and Contractor is in compliance with the provisions of this contract. the amount withheld shall be returned to Contractor, less any amount of lost federal financial participation.

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

In commercial plan contracts, amend Article III, General Terms and Conditions, Section 3.36, Minority/Women/Disabled Veteran Business Enterprises (M/W/DVBE); and in local initiative contracts amend Article III, General Terms and Conditions, Section 3.34 Minority/Women/Disabled Veteran Business Enterprises (M/W/DVBE) as follows:

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

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

RECORDS RECOVERY FOR LITIGATION

In commercial plan contracts, amend Article III, General Terms and Conditions, Section 3.45, Records Related to Recovery for Tobacco Related Illnesses, and Subsection 3.45.1, Records; and in local initiative contracts, amend Article III, General Terms and Conditions, Section 3.43, Records Related to Recovery for Tobacco Related Illnesses, and Subsection 3.43.1, Records as follows:

3.45 RECORDS RELATED TO RECOVERY FOR TOBACCO - L I T I G A T I O N

3.45.1 Records

~~DHS has filed a lawsuit for the recovery of medical expenses paid for the treatment of tobacco related illnesses, (People of the State of California ex rel. Daniel E. Lungren, Attorney General of the State of California; S. Kimberly Belshé, Director of Health Services of the State of California v. Philip Morris, Inc.; R.J. Reynolds Tobacco Company; Brown & Williamson Tobacco Corporation; B.A.T. Industries P.L.C.; Lorillard Tobacco Company, Inc.; American Tobacco Company, Inc.; United States Tobacco Company; Hill & Knowlton, Inc.; The council for Tobacco Research U.S.A., Inc.; Tobacco Institute, Inc.; Smokeless Tobacco Council, Inc. and Does 1 through 200, inclusive) (hereafter the "Tobacco Lawsuit").~~ Upon request by DHS, Contractor shall timely gather, preserve and provide to DHS, in the form and manner specified by DHS, any information specified by DHS, subject to any lawful privileges, in Contractor's or its subcontractors' possession, relating to ~~the~~ -threatened or pending litigation by or against DHS. (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 by any defendant in the Tobacco Lawsuit in~~ any litigation, by or against DHS. Contractor acknowledges that time may be of the **essence** in responding to such request. Contractor shall use all reasonable efforts to immediately notify DHS of any subpoenas, document production requests, or requests for records, received by Contractor or its Subcontractors related to ~~tobacco related illnesses or the incidence of disease associated with the use of tobacco products~~ this Contract or subcontracts entered into under this Contract.

CHILD SUPPORT COMPLIANCE ACT ACKNOWLEDGEMENT

In commercial plan contracts; amend Article III, General Terms and Conditions by adding Section 3.47; Child Support Compliance Act Acknowledgement; and in local initiative contracts, amend Article III, General Terms and Conditions by adding Section 3.45, Child Support Compliance Act Acknowledgement as follows:

3.47 CHILD SUPPORT COMPLIANCE ACT ACKNOWLEDGEMENT

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

- A. The Contractor recognizes the **importance** of child and family support obligations and shall fully comply with **all applicable** state and federal laws relating to child and family **support** enforcement, including, but not limited to, disclosure of information and compliance with **earnings and assignment orders**, as provided in Chapter 8 (commencing with section 5200) of Part 5 of Division 9 of the **Family Code**; and
- B. The Contractor, to the best of its knowledge is **fully complying** with the **earnings & assignment orders** of all employees and is providing the names of all new employees to the New Hire **Registry** maintained by the **California Employment** Development Department.
- C. Questions about the New **Employee Registry** and reporting requirements are to be directed to the **California Employment** Development Department.

NON-PHYSICIAN MEDICAL PRACTITIONERS

In commercial plan and local initiative contracts, amend Article VI, Scope of Work, Section 6.6, Provider Network and Geographic Access, Subsection 6.6.4, Access Requirements as follows:

6.6.4 Access Requirements

The Contractor shall ensure that each Member has a Primary Care Physician or a Nonphysician Medical Practitioner if such providers are included in the Contractor's provider network who is available and physically present at the service site for sufficient time to ensure access for the assigned Member upon request by the Member or when medically required and to personally case manage the Member on an on-going basis.

The Contractor will ensure Members access to all Medically Necessary specialists through staffing, subcontracting, or referral. Contractor will ensure adequate staff within the Service Area, including Physicians, administrative and other support staff directly and/or through Subcontracts, sufficient to assure that health services will be provided consistent with all specified requirements.

In commercial plan and local initiative contracts, amend Article VI, Scope of Work, Section 6.9, Member Services/Grievance System, Subsection 6.9.9, Primary Care Physician Selection as follows:

6.9.9 Primary Care Physician Selection

Contractor shall implement and maintain DHS approved procedures to ensure that each new Member has an appropriate and available Primary Care Physician. Contractor shall provide each new Member an opportunity to select a Primary Care Physician within the first thirty (30) days of enrollment. If the Contractor's provider network includes ~~nurse practitioners or certified nurse midwives~~ Non-Physician Medical Practitioners, the Member may select a ~~nurse practitioner or~~ -Non-Physician Medical Practitioner within thirty (30) days of enrollment to provide Primary Care services. Contractor shall ensure that the Member who selects a Non-Physician Medical Practitioner is also assigned to a Primary Care Physician who is responsible for the medical coordination of the Member's care and serves in a consultative, collaborative or supervisory relationship to the Non-Physician Medical Practitioner consistent with federal and State statutes and regulations. ~~the plan shall ensure that a primary care physician is responsible for the overall coordination of the Member's health care, consistent with applicable state and federal laws and regulations.~~

NON-PHYSICIAN MEDICAL PRACTITIONERS (Continued)

Contractor shall ensure that Members are allowed to change a Primary Care ~~Physician, nurse practitioner or certified nurse midwife,~~ or Non-Physician Medical Practitioner. upon request, by selecting a different Primary Care Provider from Contractor's network of providers. Contractor shall provide the Member **sufficient** information (verbal and written) in the appropriate language and reading level about the selection process and the available providers in the network, including ~~certified nurse midwives and certified nurse practitioners,~~ Non-Physician Medical Practitioners. to ensure their &ability to make an informed decision.

MAJOR ORGAN TRANSPLANTS

In commercial plan and local initiative contracts, amend Article VI, Scope of Work, Section 6.7.2, Excluded Services: Circumstances Under Which Member Disenrolled, Subsection 6.7.2.1, Major Organ Transplants as follows:

6.7.2.1 Major Organ Transplants

Except for kidney transplants, ~~major organ transplant procedures are not covered under the Contract. These procedures are bone marrow transplants, heart transplants, liver transplants, lung transplants, heart/lung transplants, combined liver and kidney transplants, combined liver and small bowel transplants.~~ major organ transplant procedures are not

When a Member is identified as a potential major organ transplant candidate, the Contractor will refer the Member to a Medi-Cal approved transplant center. If the transplant center Physician considers the Member to be a suitable candidate, the Contractor will submit a Prior Authorization Request to either the Medi-Cal Field Office (for adults) or the California Children Services Program (for children) for approval. The Contractor will initiate Disenrollment of the Member when all of the following has occurred: referral of the Member to the organ transplant Facility, the Facility's evaluation concurred that the Member is a candidate for an major organ transplant and the major organ transplant is authorized by either DHS' Medi-Cal Field Office (for adults) or the California Children Services Program (for children).

Upon Disenrollment, the Contractor will ensure continuity of care by transferring all of the Member's medical documentation to the transplant Physician. The effective date of the Disenrollment will be retroactive to the beginning of the month in which the major organ transplant is approved. All services provided during this month will be billed FFS.

If the Member is evaluated and determined not to be a candidate for a major organ transplant or DHS denies authorization for a transplant, the Member will not be disenrolled. The cost of the evaluation and responsibility for the continuing treatment of the Member will remain with the Contractor.

DUAL PARTICIPATION IN THE MSSP AND MEDI-CAL MANAGED CARE
/Continued)

In commercial plan and local initiative contracts, amend Article VI, Scope of Work, Section 6.7.2.2 as follows:

6.7.2.2 Waiver Programs

Contractor shall maintain systems for identifying and referring Members to the appropriate waiver program, including the In-Home Medical Care -Waiver, Program, the Skilled Nursing Facility Waiver Program, the Model Waiver Program, and the Acquired Immune Deficiency Syndrome (AIDS) and AIDS R e l a t e d C o n d i t i o n s W a i v e r P r o g r a m - ~~Program~~. If the agency administering the waiver program concurs with Contractor's assessment of the Member and there is available placement in the waiver program, Contractor shall initiate Disenrollment for the Member. Contractor shall provide documentation to ensure the Member's orderly transfer to the Medi-Cal Fee-For-Service program. If the Member does not meet the criteria for the waiver program, or if placement is not available, Contractor shall continue to case manage and provide all Medically Necessary Covered Services to the Member.

ALCOHOL AND DRUG TREATMENT SERVICES

In commercial plan and local initiative contracts, amend Article VI, Scope of Work, Section 6.7.3, Excluded Services: Circumstances Under Which Member Enrolled With Service Carve Out, Subsection 6.7.3.4, Alcohol and Drug Treatment Services as follows:

6.7.3.4 Alcohol and Drug Treatment Services

Alcohol and drug treatment services available under the ~~Short-Doyle-Drug~~ Medi-Cal program as defined in Title 22, CCR, Section 5 1341.1, and outpatient heroin ~~detoxification as defined in Title 22, CCR, Section 51328,~~ services s provided for in Title 22, California Code of Regulations, Section 5 1328 are excluded from this Contract.

The Contractor will arrange and coordinate Medically Necessary services, including referral of Members requiring alcohol and drug treatment to ~~SDMC alcohol and drug treatment programs~~ Drug Medi-Cal substance abuse services including outpatient heroin detoxification providers. The Contractor will assist Members in locating available treatment Service Sites. To the extent that treatment slots are not available within the Contractor's geographical Service Area, the Contractor is encouraged to pursue placement outside the area.

COVERED SERVICES .

Excluded Drugs

In commercial plan and local initiative contracts, amend Article VI, Scope of Work, Section 6.7.3, Excluded Services: Circumstances Under Which Member Enrolled With Service Carve Out, by adding Subsection 6.7.3.9, Excluded Drugs for the Treatment of HIV and AIDS as follows:

6.7.3.9 Excluded Drugs for the Treatment of HIV and AIDS

Reimbursement to pharmacies for those drugs for the treatment of HIV/AIDS listed in Attachment II (consistinn of one page) and HIV/AIDS drugs classified as Nucleoside Analogues or Nucleoside Reverse Transcriptase Inhibitors, Non-Nucleoside Reverse Transcriptase Inhibitors and Protease Inhibitors approved by the FDA after (date). shall be made by DHS through the Medi-Cal FFS program, whether these drugs are provided by a pharmacy contracting with Contractor or by an out-of-plan pharmacy provider. To qualify for reimbursement under this provision, a pharmacy must be enrolled as a Medi-Cal provider in the Medi-Cal FFS program.

COVERED SERVICES (Continued)

Excluded Drugs'

In commercial plan and local initiative contracts, amend Attachment II, Excluded Drugs for Treatment of HIV and AIDS as follows:

ATTACHMENT II

EXCLUDED DRUGS FOR THE TREATMENT OF HIV AND AIDS

~~Crixivan~~
~~Epivir~~
~~Invirase~~
~~Norvir~~
~~Viracept~~
~~Viramune~~
~~Rescriptor~~
~~Zerit~~
Abacavir Sulfate (Ziagen)
Amprenavir (Agenerase)
Delavirdine Mesylate (Rescriptor)
Efavirenz (Sustiva)
Indinavir Sulfate (Crixivan)
Lamivudine (Epivir)
Nelfinavir Mesylate (Viracept)
Nevirapine (Viramune)
Ritonavir (Norvir)
Saquinavir (Fortovase)
Saquinavir Mesylate (Invirase)
Stavudine (Zerit)
Zidovudine/Lamivudine (Combivir)

COVERED SERVICES (Continued)

Excluded Drugs

In commercial plan and local initiative contracts, amend Attachment III, Excluded Psychotherapeutic Drugs as follows:

ATTACHMENT III

EXCLUDED PSYCHOTHERAPEUTIC DRUGS

Generic Name

Amantadine HCL
Benztropine Mesylate
Biperiden HCL
Biperiden Lactate
Chlorpromazine HCL
Chlorprothixene
Clozapine
Fluphenazine Decanoate
Fluphenazine Enanthate
Fluphenazine HCL
Haloperidol
Haloperidol Decanoate
Haloperidol Lactate
Isocarboxazid
Lithium Carbonate
Lithium Citrate
Loxapine HCL
Loxapine Succinate
Mesoridazine Besylate
Molindone HCL
Olanzapine
Perphenazine
Phenelzine Sulfate
Pimozide
Procyclidine HCL
Promazine HCL
Quetiapine
Risperidone
Thioridazine HCL
Thiothixene
Thiothixene HCL
Tranlycypromine Sulfate
Trifluoperazine HCL
Trifluoperazine HCL
Trihexyphenidyl HCL

1998 KNOX-KEENE DISCLOSURE REQUIREMENTS

In commercial plan and local initiative contracts, amend Article VI, Scope of Work, Section 6.9.5, Membership Services Guide as follows:

6.9.5 Membership Services Guide

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

- A. The name, address and telephone number of the health plan.
- B. A description of the full scope of Medi-Cal covered benefits and all available services including health education, interpretive services, and “carve out” services and an explanation of any service limitations and exclusions from coverage or charges for services.
- C. Procedures for obtaining Covered Services including the address and telephone number of each Service Site (e.g., locations of hospitals, Primary Care Physicians, optometrists, psychologists, pharmacies, Skilled Nursing Facilities, Urgent Care Facilities). In the case of a medical foundation or independent practice association, the address and telephone number of each Physician provider.
 - 1. The hours and days when each of these Facilities is open, the services and benefits available, and the telephone number to call after normal business hours.
- D. Procedures for selecting or requesting a change in Primary Care Physician, including requirements for a change in PCP; reasons for which a request may be denied; and reasons why a provider may request a change.
- E. The purpose **and** value of scheduling an initial health assessment appointment.
- F. The appropriate use of health care services in a managed care system.
- G. The availability and **procedures for** obtaining after hours services (24-hour basis) and care, including the appropriate provider locations and telephone numbers.
- H. Procedure for obtaining emergency health care both within and outside Contractor’s Service Area.

- I. Process for referral to specialists.
- J. Procedures for obtaining any non-medical transportation services offered by Contractor and through the local CHDP programs, and how to obtain such services.
- K. The causes for which a Member shall lose entitlement to receive services under this Contract. (See Article III, Section 3.23 .5, Disenrollment)
- L. Procedures for filing a complaint/Grievance, including procedures for appealing decisions regarding Member's coverage, benefits, or relationship to the organization. Include the title, address, and telephone number of the person responsible for processing and resolving complaints/Grievances.
- M. Procedures for Disenrollment, including an explanation of the Member's right to **disenroll** without cause at any time, subject to any restricted disenrollment period.
- N. Information on the Member's right to the Medi-Cal fair hearing process regardless of whether or not a complaint/Grievance has been submitted or if the **complaint/Grievance** has been resolved, pursuant to Title 22, CCR, Section 53452, when a health care service requested by the Member or provider has been denied, deferred or modified. The State Department of Social Services' Public Inquiry and Response Unit toll-free telephone number (1-800-952-5253).
- O. Information on the availability of, and procedures for obtaining, services at **FQHCs** and Indian Health Clinics.
- P. Information on the Member's right to seek family planning services from any qualified provider of family planning services under the Medi-Cal program, including providers outside Contractor's provider network, and a description of those services, such as the following statement:

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

- Q. DHS' Office of Family Planning toll-free telephone number (1-800-942-1054) providing consultation and referral to family planning clinics.
- R. Any other information determined by DHS to be essential for the proper receipt of Covered Services.
- S. Information on the availability of, and procedures for obtaining, Certified Nurse Midwife and Certified Nurse Practitioner services, pursuant to Section 6.7.4.14, Nurse Midwife and Nurse Practitioner Services.
- T. Information on the availability of transitional Medi-Cal eligibility and how the Member may apply for this program. Contractor shall include this information with all Membership Service Guides sent to Members after the date such information is furnished to Contractor by DHS.
- U. Information on how to access State resources for investigation and resolution of Member complaints, including the DHS Medi-Cal Managed Care Ombudsman toll-free telephone number (1-888-452-8609) and the DOC HMO Consumer Service toll-free telephone number (1-800-400-0815).
- V. Information concerning the provision and availability of services covered under the CCS program from providers outside Contractor's provider network and how to access these services.
- W. An explanation of the expedited **disenrollment** process for children receiving services under the Foster Care or Adoption Assistance Programs; Members with special health **care needs**, including, but not limited to major organ transplants; and Members already enrolled in another Medi-Cal, Medicare or commercial managed care plan.
- X. Information on how to obtain Minor Consent Services through Contractor's plan, and an explanation of those services.
- Y. A brief explanation on how to use the Fee-For-Service system when Medi-Cal covered services are excluded or limited under this Contract and how to obtain additional information.
- Z. An explanation of an American Indian Member's right to access Indian Health Service facilities and to disenroll from Contractor's plan at any time, without cause.
- AA. Subsections S through Z above, except subsection T, shall be included in Contractor's Membership Services Guide by April 1, 1999, or upon the next reprinting of Contractor's Membership Services Guide, whichever is sooner.

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

CC. A statement as to whether ~~if the plan~~ uses provider financial bonuses or other incentives with its **contracting** providers of health care services and that the Member may request additional information about these bonuses or incentives from the **plan**, the Member's provider or the Provider's medical **group** or independent **practice** association.; **pursuant to** California Health and Safety Code, Section 1367.10.

DD. A notice as to whether the **plan** uses a drug formulary.~~~a drug formulary, including an explanation of what a formulary is, how the plan decides which prescription drugs are included in or excluded from the formulary, and how often the formulary is updated.~~ Pursuant to California Health and Safety Code, Section 1363.01. ~~this the~~ notice shall: (1) be in the **language** that is **easily** understood and in a format that is easy to understand; (2) include an explanation of what a formulary is, how the **plan** decides which **prescription drugs** are included in or excluded from the formulary, and how often the formulary is updated; (3) indicate that the Member can request information regarding whether a **specific** drug; is on the formulary and the telephone number for **requesting** this information; and (4) indicate that the **presence** of a drug, on the plan's formulary does not guarantee that a Member will be prescribed that drug by his or her prescribing provider for a **particular medical condition**. 3 ~~information regarding whether a specific drug is on the formulary and the telephone number for requesting this information.~~

EE. Subsections BB through ~~EE-DD~~ above shall be included in the Contractor's Membership Services Guide **upon** the next **reprinting** of the Contractor's Membership Services Guide.

CONTINUITY OF CARE AND CASE MANAGEMENT

Health Assessment; Standing Referrals to Specialist or Specialty Care Center; and Continuation of Care With Terminated Providers

In ~~COHS~~ COHS contracts, amend Article 7.1.1, and in Local Initiative and Commercial two-plan contracts amend Article 6, subsection 6.5.10 Continuity of Care and Case Management as follows:

In providing or arranging for the provision of Covered Services, Contractor shall:

- .1 **Health Assessment**
Develop, implement, and maintain procedures for the performance of an initial health assessment for each Member within 120 calendar days of Enrollment, or less for those members for whom the American Academy of Pediatrics recommended periodic health assessment is due in fewer than 120 days following enrollment.
- .2 **Referrals and Follow-Up Care**
Develop, implement, and maintain an adequate system for tracking all referrals and follow-up care.
- .3 **Coordination of Care**
Maintain procedures for monitoring and measuring the coordination of care provided to the Members in all settings, including, but not limited to, coordination of discharge planning from inpatient Facilities and coordination of all Medically Necessary services both within and outside Contractor's provider network.
- .4 **Missed/Broken Appointments**
Implement and maintain **policies** and procedures to follow-up on missed/broken appointments.
- .5 **Continuity of Care**
Ensure continuity of care from the Ambulatory Care setting to the inpatient care setting and all other care settings as needed.
- .6 **Standing Referrals to a Specialist or Specialty Care Center**
Implement and maintain **policies** and procedures to **comply** with the requirements of Section 1374.16 of the Health and Safety Code.
- .7 **Continuation of Care With Terminated Providers**
Implement and maintain **policies** and **procedures** to assure continuation of care for **enrollees with terminated providers** in a manner consistent with the requirements of Section 1373.96 of the Health and Safety Code.

**Amendment Language
Commercial and Local Initiative Plan Contracts**

1. **In commercial and local initiative contracts, amend Article II, DEFINITIONS, Section RR, Health Plan Employer Data and Information Set (HEDIS), to read:**

RR. Health Plan Employer Data and Information Set (HEDIS) means the set of standardized performance measures sponsored and maintained ~~developed~~ by the National Committee for Quality Assurance (NCQA); ~~a not for profit organization. HEDIS is designed to ensure that the public has the information it needs to reliably compare the performance of managed health care plans.~~

2. **In commercial and local initiative contracts, amend Article II, DEFINITIONS to add the following new definitions, A3- H3, to read:**

A3 HEDIS Compliance Audit means an audit process that uses specific standards and guidelines for assessins the collecting, storing, analyzing, and reporting of HEDIS measures. This audit process is designed to ensure accurate HEDIS reporting.

B3 Internal Quality Improvement Projects (IQIPs) means studies selected by Medi-Cal Managed Care Plans to be used for their internal auality improvement purposes. The studies include an initial report, four (4) phases with reports and a final report.

c3 Minimum Performance Level refers to a minimum requirement of performance of Contractor on each of the HEDIS measures selected by DHS.

D3 National Committee on Quality Assurance (NCQA) is a non-profit organization committed to evaluating and publicly reporting on the quality of manaaed care plans.

E3 NCQA Licensed Audit Organization is an entity licensed to provide auditors certified to conduct HEDIS Compliance Awards.

F3 **Not Report** means: 1) Contractor did not calculate the measure and a population exists for which the measure could have been calculated; 2) Contractor calculated the measure but the result was in error: a) for measures reported as a rate (e.g. effectiveness of care measures) any error that causes a (+/-) five (5) percentage point difference in the reported rate; b) for non-rate measures (e.g. Use of Services measures) any error that causes a (+/-) ten (10) percent change in the reported event.

G3 **Significant Improvement** means a reduction in the performance gap, which is further defined by the reduction of a least ten percent in the number of Members that do not achieve the desired outcome. This can also be defined as demonstrating that an improvement measured is statistically significant with a p value of less than or equal to 0.10.

H3 **Sustained Improvement** means that the organization sustains the improvement in performance for at least one year after the improvement in performance is first achieved. Sustained improvement is documented through the continued measurement of Quality Indicators for at least one year after the performance improvement project is completed.

3. **In commercial and local initiative contracts, amend Article III, TERMS AND CONDITIONS, Sections 3.19 and 3.17 Sanctions, to read:**

3.19 SANCTIONS

At the event DHS finds Contractor non-compliant with any provisions of this Contract, applicable governing statutes or regulations, ~~or for good cause shown~~, DHS may impose sanctions provided in Welfare and Institutions Code, Section 14304 and Title 22, CCR, Section 53872 as modified for purposes of this contract. Title 22, CCR, Section 3872 is so modified as follows:

- 1) Subsection (b)(1) is modified by replacing "Article 2" with "Article 6"
- 2) Subsection (b)(2) is modified by replacing "Article 3" with "Article 7"

~~Good cause includes, but is not limited to, three repeated and uncorrected findings of serious deficiencies that have~~

~~the potential to endanger patient care identified in the medical audits conducted by DHS.~~

B. The requirements of Sections 6.5.3.1 through 6.5.3.8 are all contract provisions which are not specifically governed by Chapter 4.1 (commencing with Section 53800) of Division 3 of Title 22, CCR. Therefore, sanctions for violations of the requirements of Sections 653.1 through 653.8 shall be governed by Subsection 53872 (b)(4).

C. For purposes of contract termination, good cause includes, but is not limited to, the following:

1) Three repeated and uncorrected findings of serious deficiencies that have the potential to endanger patient care identified in the medical audits conducted by H S .

2) In the case of Sections 6.5.3.1 through 6.5.3.8, the Contractor consistently fails to achieve the minimum performance levels, or receives a "Not Report" designation on a HEDIS measure, after implementation of Corrective Actions, or fails to achieve Significant Improvement and Sustained Improvement on more than three occasions.

D. If required by DHS, Contractor shall ensure subcontractors cease specified activities which may include, but are not limited to, referrals, assignment of beneficiaries, and reporting, until DHS determines that Contractor is again in compliance.

4. **In commercial and local initiative contracts, amend Article IV, DUTIES OF THE STATE, Section 4.9, Sanctions, to read:**

4.9 SANCTIONS

Apply sanctions to Contractor for violations of the terms of this Contract, applicable federal and State laws and regulations, in accordance with Welfare and Institutions Code , Section 14304, and Title 22, CCR, Section 53872, as modified for purposes of this Contract. Title 22, CCR, Section 53872 is so modified as follows:

3) Subsection (b)(1) is modified by replacing "Article 2" with "Article 6"

4) Subsection (b)(2) is modified by replacing "Article 3" with "Article 7".

~~to Contractor for violations of the terms of this Contract, applicable to federal and State laws and regulations.~~

5. **In commercial and local initiative contracts, amend Article VI, SCOPE OF WORK, Section 6.4.2, Encounter Data Submittal, to read:**

6.4.2 Encounter Data Submittal

Contractor shall implement policies and procedures for ensuring the complete, accurate, and timely submission of Encounter-level data for all services for which Contractor has incurred any financial liability, whether directly or through Subcontracts or other arrangements. As a condition of payment, Contractor may require subcontractors and out-of-plan providers to provide Encounter-level data to Contractor that meets the same standards required for Contractor to comply with this-section. Contractor shall have in place a mechanism to validate that Encounter level data is complete and accurate prior to submission to DHS. Contractor shall submit Encounter-level data to DHS on a monthly basis, no later than ninety (90) days following the end of the reporting month in which the Encounter occurred, in the form and manner specified in DHS' most recent Managed Care Data Element Dictionary. Encounter-level data received and processed by Contractor too late to be submitted timely, shall be submitted to DHS with the next monthly submission. Encounter-level data shall include data elements specified in DHS' most recent Managed Care Data Element Dictionary.

6. **In commercial and local initiative contracts, amend Article VI, SCOPE OF WORK, Section 6.5.1.1, Written Description, to read:**

6.5.1.1 Written Description

The Contractor will implement and maintain a written description of its QIP which will include the following:

- A.. Organizational commitment to deliver quality health care services, goals, and objectives, including accreditation of its QIP program, which are evaluated and updated annually and include a time table for implementation and accomplishment.

- B. Organizational chart showing the key persons, the committees and bodies responsible for Quality Improvement, reporting relationships of QIP committees within the

Contractor's organization, and provisions for support staff including reporting relationships.

- C. Qualifications of staff responsible for Quality Improvement studies and activities including appropriate education, experience and training.
- D. The QIP scope of review, which must include:
 - 1. Quality of clinical care services including, but not limited to, preventive services, prenatal care, and family planning services.
 - 2. Quality of nonclinical services including, but not limited to, availability, accessibility, coordination and continuity of care.
 - 3. Representation of the entire range of care provided by the Contractor, including all demographic groups, (age, sex, language ethnicity) care settings (e.g., emergency services, inpatient, ambulatory, and home health care) and types of services (e.g. preventive, primary, specialty, and ancillary).
- E. A description of specific Quality of Care studies and other activities to be undertaken over a prescribed period of time, the responsible individuals, organizational resources utilized to accomplish them, methodologies to be used, including but not limited to those that address health outcomes, and mechanisms for tracking issues over time.
- F. A description of a system for provider review of the QIP which at a minimum, demonstrates Physicians' and other professionals' involvement and provisions for providing feedback to staff and providers, regarding performance and outcomes.
- G. A description of the annual QIP report will include a summary of all QIP studies and other activities completed; trending of clinical and service indicators and other performance data; areas of deficiency and Corrective Actions undertaken; an evaluation of the overall effectiveness of the QIP, and evidence that activities have contributed to significant improvements in care delivered to Members.

7. **In commercial and local initiative contracts, amend Article VI SCOPE OF WORK, Section 6.5.2.7, Coordination With Other Management Activities, to read:**

6.5.2.7 Coordination With Other Management Activities

The Contractor will implement and maintain Quality Improvement channels and facilitate coordination with other performance monitoring activities, including risk management, and resolution, and monitoring of Member Complaints and Grievances. The Contractor's QIP will maintain linkages with other management functions such as, network changes, medical management systems, (i.e., pre-certification), practice feedback to physicians, patient education/health education, Member Services, and-human resources, and cultural and linguistic services feedback.

8. **In commercial and local initiative contracts, amend Article VI SCOPE OF WORK, Section 6.5.3.1 General Requirements, to read:**

653.1 General Requirements

The Contractor's QIP will objectively and systematically monitor and evaluate the quality and appropriateness of care and services rendered on an ongoing basis. The Contractor will implement a Quality Improvement Plan that addresses the quality of clinical care, as well as the auality of health services deliver-v. conduct ~~Quality of Care studies that address the quality of clinical care as~~ & T h e C o n t r a c t o r w i l l ensure that the studies described below reflect the population served in terms of age groups, disease categories, and special risk status. The Quality Improvement Plan will ~~These studies will~~ continuously monitor care against practice guidelines or clinical standards and will use appropriate Quality Indicators as measurable variables. The Contractor will ensure that data collected will be analyzed by the appropriate health professionals, and system issues will be addressed by multi-disciplinary teams. The Contractor will undertake Corrective Actions within the timeframes determined by DHS whenever problems are identified. The Contractor will maintain a system for tracking the issues over time to ensure that actions for improvement are effective.

9. In commercial and local initiative contracts, amend Article VI SCOPE OF WORK, Section 6.5.3.2, by deleting it in its entirety and renaming as Quality Performance Measures Reporting, to read:

6.5.3.2 Quality Performance Measures Reporting ~~Quality of Care Studies~~

The Contractor will report audited results for a minimum of seven (7) Health Plan Employer Data Information Set (HEDIS) measures each calendar year. These measures will be selected by DHS after taking into consideration the recommendations of the Quality Improvement Workgroup. These measures will be reported in accordance with National Committee on Quality Assurance (NCQA) specifications and timelines, unless otherwise specified by DHS. The results of the HEDIS measures will be audited by a NCQA Licensed Audit Organization.

The DHS contracted External Quality Review Organization (EQRO), and NCQA Licensed Audit Organization will conduct the HEDIS compliance audit for all Contractors at no cost. The Contractor is permitted to continue to use another NCQA Licensed Audit Organization at its own expense, if Contractor had already contracted, in 1998, with another NCQA Licensed Organization.

If the Contractor had already contracted with another NCQA Licensed Audit Organization in 1998 and wishes to continue association with the non-DHS contracted NCQA Licensed Audit Organization, the Contractor must notify DHS in writing of this intent, and submit the name of the NCQA Licensed Audit Organization that will be used by January 15 of each contract year. If a non-DHS contracted NCQA Licensed Audit Organization is used, Contractor must ensure that the NCQA Licensed Audit Organization submits a COPY of the HEDIS compliance audit report to DHS in accordance with NCQA timelines, unless specified otherwise by DHS.

The minimum performance levels for each HEDIS measure will be determined by DHS. The Contractor will achieve or exceed the DHS established minimum performance level for each HEDIS measure. If the Contractor fails to achieve the minimum performance level for any of the measures or receives a "Not Report" for any of the measures, Contractor will develop and implement Corrective Actions. The Contractor will submit the Corrective Actions to DHS for approval in accordance with the timelines specified by DHS. The Corrective Actions must permit

the Contractor to achieve or exceed the DHS established minimum performance levels in accordance with timelines approved by DHS. The Contractor will continue to report on a HEDIS measure until such time as DHS instructs the Contractor to replace the HEDIS measure with another one.

If the Contractor covers beneficiaries in more than one county under the terms of this contract, the Contractor shall submit HEDIS results based upon a sample that has representation from each county covered under the terms of this contract. The required sampling methodology for multiple county contracts will be proportional sampling, as specifically defined in Attachment IV.
~~perform eleven (11) focused studies on an ongoing basis as listed below:~~

~~A. Clinical Areas~~

- ~~1. Pediatric preventive services: immunizations and health screens.~~
- ~~2. Obstetrical care.~~
- ~~3. Adult preventive services.~~

~~B. Health Services Delivery Areas~~

- ~~1. Access to care.~~
- ~~2. Utilization of services.~~
- ~~3. Coordination of care.~~
- ~~4. Continuity of care.~~
- ~~5. Health Education.~~
- ~~6. Emergency Services.~~
- ~~7. Member satisfaction surveys.~~
- ~~8. Family planning.~~

10. In commercial and local initiative contracts, amend Article VI, SCOPE OF WORK, Section 6.5.3.3, Standards and Guidelines, to read:

6.5.3.3 Standards and Guidelines

The following standards and are for provision of Covered Services to Members under this Contract. These standards and guidelines also serve as a baseline for assessment against which care actually delivered will be measured. DHS will set minimum acceptable performance levels for these standards and guidelines after evaluation of experimental data from all Medi-Cal Managed Care Contractors and from other sources. Contractor will use these following standards and guidelines for IQIPs with topics related to health care delivery. Preventive Care as designated by DHS. The Contractor will adopt these standards and guidelines as a baseline for assessment against which care actually delivered can be compared. For Quality of Care studies in the health services delivery areas, the Contractor will use the specific standards set forth in the pertinent subsections. The Contractor's Quality of Care studies may include health services delivery issues other than the eleven (11) priority areas identified. For other clinical or health services delivery areas where DHS has not specified clinical standards or practice guidelines, the Contractor will submit these standards or guidelines to DHS for approval six weeks prior to conducting the studies.

A. Pediatric:

For pediatric care, standards for Pperiodic health screen schedules based on the most recent recommendations of the American Academy of Pediatrics (AAP). Immunization schedule based on recommendations of either the Advisory Committee on Immunization Practices, or the AAP shall be acceptable.

B. Adult:

For adult preventive care, standards are based on ~~Guidelines based on guidelines~~ contained in the Report of the United States Preventive Services Task Force.

C. Obstetric:

For obstetric care, standards are ~~Minimum standards based~~ on the most recent recommendations of the American College of Obstetrics and Gynecology. Contractors are

further required to provide risk assessment and interventions consistent with Comprehensive Perinatal Services Program (CPSP) requirements as specified in Title 22 , CCR, Sections 51348 and 51348.1.

D. Tuberculosis

For care and treatment of Members with tuberculosis (TB), standards are based on the most recent guidelines recommended by the American Thoracic Society and Center for Disease Control.

E. Other Standards

For other clinical or health service delivery areas, where DHS has not specified clinical standards or practice guidelines, the Contractor may adopt evidence based standards or guidelines after taking into consideration the recommendations of appropriate network providers.

11. **In commercial and local initiative contracts, amend Article VI SCOPE OF WORK, Section 6.5.3.4, Quality Indications by renaming as Collaborative Initiative and, amending to read:**

6.5.3.4 Collaborative Initiative **Quality Indicators**

The Contractor will undertake a joint quality improvement Collaborative Initiative that addresses a common topic among all DHS Medi-Cal Managed Care Contractors. A new Collaborative Initiative may be required by DHS on an annual basis. The Collaborative Initiative will include a standardized methodology that is to be used by all participating DHS Medi-Cal Managed Care Contractors, as well as quality indicators that reviewed and approved jointly by DHS and participating DHS Medi-Cal Managed Care Contractors. A Collaborative Initiative will be completed and reported to DHS in accordance with a timeline specified by DHS after taking into consideration recommendations from the Quality Improvement Workgroup. To the extent feasible and appropriate, Contractor shall use the most recent HEDIS indicators for the required Quality of Care studies indicated in Section 6.5.3.2, Quality of Care Studies. The HEDIS indicators selected for use by Contractor shall be approved by DHS.

12. In commercial and local initiative contracts, amend Article VI SCOPE OF WORK, Section 6.5.3.5, Reports by renaming as Internal Quality Improvement Projects and amending, to read:

6.5.3.5 Internal Quality Improvement Projects Reports

The Contractor will initiate IQIPs⁴ consisting of two (2) clinical and two (2) non-clinical projects in 1999, and initiate one (1) additional project beginning in 2001 and in each subsequent year, the total number of projects not to exceed six (6) per year. The Contractor must secure written approval from DHS prior to initiating, modifying the methodology of, or terminating any IQIP. Upon DHS approval, the Contractor may terminate an approved project and introduce another IQIP if the Contractor has achieved Significant and Sustained Improvement for two (2) years or the IQIP is abandoned due to extenuating circumstances. IQIPs may be evaluated on an annual basis by DHS or its External Quality Review Organization, based on the fifteen (15) key reporting elements described in Attachment V.

The clinical IQIP topics will pertain to the care of, as well as the primary, secondary, and/or tertiary prevention of both acute and chronic conditions. The non-clinical IQIP topics will pertain to the quality of health care delivery (e.g., availability and/or accessibility of services, cultural competency, interpersonal aspects of care, quality of provider/patient encounters, appeals, grievances, and other complaints) or may focus on Consumer Assessment of Health Plans Study (CAHPS) Version 2.OH, results when available. Only one IQIP of the maximum number of six IQIPs may focus on CAHPS 2.OH results. DHS reserves the right to require the Contractor to focus on a specific subject (clinical or non-clinical) for an IQIP. ~~All Quality of Care studies within six months of operation and the progress and/or results of these Quality of Care studies will be submitted to DHS contract managers six months after initiation of the study (due fifteen (15) days after the end of the first year of operation) and at least quarterly updates thereafter. Quarterly updates will be due fifteen (15) days after the end of the quarter.~~

13. In commerical and local initative contracts, amend Article VI SCOPE OF WORK, bv adding a new Section 6.5.3.6, Reporting Timelines. to read:

6.5.3.6 Reportinn Timelines

A. HEDIS Measures

The Contractor will report certified audited HEDIS measures to DHS on an annual basis, followinn timelines specified by DHS.

B. Collaborative Initiative

The Contractor will report results of the Collaborative Initiatie to DHS followins timelines specified by DHS.

C. Internal Quality Improvement Proiects

For each IQIP, the Contractor will submit to DHS for approval an Initial Report and a Phase I report in accordance with timelines specified by DHS. Thereafter, the Contractor will submit reports for DHS approval upon completion of each phase of an IQIP, or an annual progress report if the phase has not been completed within twelve (12) months, whichever is appropriate. As each IQIP is completed, the Contractor will submit a final report to DHS. Each report shall include information on the key reporting elements appropriate for that phase of the IQIP, as illustrated in Attachment VI.

44. In commerical and local initiative contracts, amend Article VI SCOPE OF WORK, by adding a new Section 653.7, Contract Requirements when Termination of the Contract Occurs, to read:

6.5.3.7 Contract Requirements when Termination of Contract Occurs

A. If this contract is teminated prior to the completion of a full contract year, the following sections shall survive the contract:

6.5.3.3 Collaborative Initiative

6.5.3.4 Internal Quality Improvement Proiects

Collaborative Initiatives – Contractor must submit to DHS a final status report that covers the time period from the last

report to the effective date of contract termination. This report must be submitted to DHS within ninety (90) days after the effective date of contract termination.

internal Quality improvement Projects – Contractor must submit a final status report to DHS that covers the time period from the last report to the effective date of contract termination. This report must be submitted to DHS within ninety (90) days after the effective date of contract termination.

B. If this Contract is terminated at the completion of a full contract year, the following sections shall survive the contract:

6.5.3.2 Quality Performance Measure Reporting

6.5.3.3 Collaborative Initiative

6.5.3.4 Internal Quality Improvement Project

Quality Performance Measure Reporting Contractor must submit a certified audit report of the HEDIS measures in accordance with the specifications and timelines specified by DHS or within ninety (90) days after the effective date of contract termination, whichever occurs first.

Collaborative Initiatives – Contractor must submit to DHS a final status report that covers the time period from the last report to the effective date of contract termination. This report must be submitted to DHS within ninety (90) days after the effective date of contract termination.

Internal Quality Improvement Project – Contractor must submit a final status report to DHS that covers the time period from the last report the effective date of contract termination. This report must be submitted to DHS within ninety (90) days after the effective date of contract termination.

15. In commercial and local initiative contracts, amend Article VI SCOPE OF WORK, by adding a new Section 653.8, Contract extension.

6.5.3.8 Contract Extension

If this Contract is extended, the Contractor shall comply with all provisions of this Article.

16. **In commercial and local initiative contracts, amend Article VI, SCOPE OF WORK, Section 6.5.5.2. Review Procedures, to read:**

6.552 Review Procedures

The Contractor will ensure that its Facility review procedures will be submitted to DHS for approval prior to use and will comply with all of DHS' requirements, which include the following categories:

- A. Front office procedures including:
 - 1. Telephone access, triage/advice.
 - 2. Appointment scheduling, as well as a system for coordinating interpreters for limited English Proficient (LEP) Members.
 - 3. Missed appointment and follow-up.
 - 4. Referral appointment and follow-up.
 - 5. Referral (consultation) reports, lab and X-ray follow-up.
- B. Fire and disaster plan.
- C. Infection control.
- D. Handling of bio-hazardous wastes.
- E. Health education.
- F. Medical emergencies.
- G. Pharmacy policies (including handling of sample drugs).
- H. Medical Records storage and filing.
- I. Medical Records documentation.
- J. Grievances.
- K. Laboratory services.
- L. Radiological services.
- M. Preventive services for children, adults, and pregnant women.

N. Facility access for physically disabled individuals.

O. Informed consent procedures.

P. Linguistic services access.

17. In commercial and local initiative contracts, amend Article VI, SCOPE OF WORK, by deleting Section 656.7, in its entirety.

~~6.5.6.7 Member Satisfaction Surveys~~

~~The Contractor will conduct surveys of Member satisfaction with its services, at least annually:~~

~~A. At a minimum, the surveys will include the following groups of Members: Members filing Grievance/complaints, Members requesting change of providers or Facilities, groups who speak a primary language other than English meeting threshold levels, and Members requesting Disenrollment from the Contractor.~~

~~B. The Contractor's Member survey will identify perceived problems in quality, availability and accessibility of care as well as reasons for Member's accessing care from an out of plan provider, e.g., family planning services.~~

~~C. The Contractor will use the survey to identify sources of dissatisfaction, outline action steps to follow up on the findings, inform providers of the results, and reevaluate the effects of the actions taken.~~

18. In commercial and local initiative contracts, amend Article VI, SCOPE OF WORK, Section 6.5.7.6, Telephone Procedures, to read:

6.5.7.6 Telephone Procedures

The Contractor will maintain a procedure for triaging Members' telephone calls, & providing telephone medical advice and accessing telephone interpreter.

19. **In commercial and local initiative contracts, amend Article VI, SCOPE OF WORK, Section 6.5.8.4, Member Medical Record, to read:**

6.5.8.4 Member Medical Record

Contractor shall ensure that a complete Medical Record shall be maintained for each Member in accordance with Title 22, CCR, Section 53861, and it shall reflect all aspects of patient care, including ancillary services, and at a minimum shall include:

- A. Member identification on each page; personal/biographical data in the record.
- B. All entries dated and author identified; the entries will include at a minimum, the subjective complaints, the objective findings, and the plan for diagnosis and treatment.
- C. The record will contain a problem list, a complete record of immunizations and health maintenance, or preventive services rendered.
- D. Allergies and adverse reactions are prominently noted in the record.
- E. All informed consent documentation, including the human sterilization consent procedures required by Title 22, CCR, Sections 51305.1 through 51305.6, if applicable.
- F. All emergency care provided (directly by the contracted provider or through an emergency room) and the hospital discharge summaries for all hospital admissions while the patient is enrolled.
- G. All consultations, referrals, and specialists' reports, and all pathology and laboratory reports. Any abnormal results will have an explicit notation in the record.
- H. For Medical Records of adults, documentation of whether the individual has been informed and has executed an advanced directive such as a Durable Power of Attorney for Health Care.

- I. Member's preferred language (if other than English) is prominently noted in the record, as well as the Request or refusal of language/interpretation services.
- J. Health education behavioral assessment and referrals to health education services. For patients 12 years or older, a notation concerning use of cigarettes, alcohol, and substance abuse, health education, or counseling and anticipatory guidance.

20. In commercial and local initiative contracts, amend Article VI, SCOPE OF WORK, Section 6.6.12, Quarterly Report, to read:

6.6.12 Quarterly Report

Contractor shall submit to DHS on a quarterly basis, in a format specified by DHS, a report summarizing changes in the provider network. The report shall identify provider deletions and additions and the resulting impact to: 1) geographic access for the Members; 2) cultural and linguistic services including provider and provider staff language capability; 3) the targeted percentage of traditional and safety-net providers; 4) the ethnic composition of providers, if known; and 5) the number of Members assigned to Primary Care Physicians and the percentage of Members assigned to traditional and safety-net providers. Contractor shall submit the report thirty (30) days following the end of the reporting quarter.

21. In commercial and local initiative contracts, amend Article VI, SCOPE OF WORK, Section 6.7.7.3, Individual Health Education Behavioral Assessments, to read:

6.7.7.3 Individual Health Education Behavioral Assessments

Contractor shall ensure that individual health education behavioral assessments are conducted on all Members within 120 days of Enrollment to determine health practices, values, language preference, behaviors, knowledge, attitudes, cultural practices, beliefs, literacy levels, and health education needs. Upon Contractor's written request, DHS may, at its discretion, delay Contractor implementation of this requirement. DHS shall approve any such request in writing. DHS may terminate any approved delay in implementation thirty (30) days after DHS' notice to Contractor of intent to terminate.

22. **In commercial and local initiative contracts, amend Article VI, SCOPE OF WORK, Section 6.7.7.8, Health Education Workplace, by deleting it in its entirety.**

~~6.7.7.8 Health Education Workplace~~

~~If the Contractor does not comply with all of the requirements in Sections 6.7.7.1 through 6.7.7.9 upon implementation of the Contract, the Contractor will comply with all of the requirements for the provision of health education services except for the requirements in Section 6.7.7.6. Contractor will submit for DHS' approval a proposed workplan for meeting the full scope of requirements by the end of one year of operations under this Contract. Contractor will include in the workplan a description of the required activities, a timeline with milestones, and identify the responsible individuals and the individual with overall responsibility. The Contractor will entitle the workplan "Health Education Services: Proposed Activities".~~

23. **In commercial and local initiative contracts, amend Article VI, SCOPE OF WORK, by renumbering Section 6.7.7.9 as Section 6.7.7.8, Health Education Reading Level.**
24. **In commercial and local Initiative contracts, amend Article VI, SCOPE OF WORK, Section 6.8.1, Marketing Representatives, to read:**

6.8.1 Marketing Representatives

Contractor shall ensure, in addition to compliance with the requirements of Title 22, CCR, Section 53880, that:

- A. All Marketing Representatives including supervisors, have satisfactorily completed the Contractor's Marketing orientation and training program and the DHS Marketing Representative Certification Examination prior to engaging in Marketing activities on behalf of the Contractor.
- B. A Marketing Representative will not provide Marketing services on behalf of more than one Contractor.
- C. Marketing Representatives do not engage in Marketing practices that discriminate against an Eligible Beneficiary because of race, creed, lanquaae, age, color, sex, religion, national origin, ancestry, marital status, sexual orientation, physical or mental handicap, or health status.

25. In commercial and local initiative contracts, amend Article VI, SCOPE OF WORK, by amending Section 6.9.5, Membership Services Guide, to read:

6.9.5 Membership Services Guide

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

- A. The name, address, and telephone number of the health plan.
- B. A description of the full scope of Medi-Cal covered benefits and all available services including health education, interpreter ~~interpretive~~ services, “carve out” services, and an explanation of any service limitations and exclusions from coverage or charges for services.
- C. Procedures for obtaining Covered Services including the address and telephone number of each Service Site (i.e., locations of hospitals, Primary Care Physicians, optometrists, psychologists, pharmacies, Skilled Nursing Facilities, Urgent Care Facilities). In the case of a medical foundation or independent practice association, the address and telephone number of each Physician provider.
 - 1. The hours and days when each of these Facilities is open, the services and benefits available, and the telephone number to call after normal business hours.
- D. Procedures for selecting or requesting a change in Primary Care Physician, including requirements for a change in PCP; reasons for which a request may be denied; and reasons why a provider may request a change.
- E. The purpose and value of scheduling an initial health assessment appointment.
- F. The appropriate use of health care services in a managed care system.
- G. The availability and procedures for obtaining after hours services (24-hour basis) and care, including the appropriate provider locations and telephone numbers.
- H. Procedure for obtaining emergency health care, both within and outside Contractor’s Service Area.

- I. Process for referral to specialists.
- J. Procedures for obtaining any non-medical transportation services offered by Contractor and through the local CHDP programs, and how to obtain such services.
- K. The causes for which a Member shall lose entitlement to receive services under this Contract. (See Article III, Section 3.23.5, Disenrollment)
- L. Procedures for filing a Complaint/Grievance, including procedures for appealing decisions regarding Member's coverage, benefits, or relationship to the organization. Include the title, address, and telephone number of the person responsible for processing and resolving Complaints/Grievances.
- M. Procedures for Disenrollment, including an explanation of the Member's right to disenroll without cause at any time, subject to any restricted disenrollment period.
- N. Information on the Member's right to the Medi-Cal fair hearing process regardless of whether or not a Complaint/Grievance has been submitted or if the Complaint/Grievance has been resolved, pursuant to Title 22, CCR, Section 53452, when a health care service requested by the Member or provider has been denied, deferred or modified. The State Department of Social Services' Public Inquiry and Response Unit toll free telephone number **(800) 95245253**.
- O. Information on the availability of, and procedures for obtaining, **services at FQHCs and Indian Health Clinics.**
- P. Information on the Member's right to seek family planning services from any qualified provider of family planning services under the Medi-Cal program, including providers outside Contractor's provider network, **and** a description of those services, such as the following **s t a t e m e n t :**

"Family planning services are provided to Members of child bearing age to enable them to determine the number and spacing of children. These services include all methods of birth control approved by the Federal Food and Drug Administration. As a Member, you pick a doctor who is located near you and will give you the services you need. Our Primary Care Physicians and OB/GYN specialists are available for family planning services. For

family planning services, you may also pick a doctor or clinic not connected with [Plan Name(Contractor)] without having to get permission from [Plan Name (Contractor)& [Plan Name (Contractor)] shall pay that doctor or clinic for the family planning services you get”.

- Q. DHS’ Office of Family Planning’s toll free telephone number (1-800-942-1 054) providing consultation and referral to family planning clinics.
- R. Any other information determined by DHS to be essential for the proper receipt of Covered Services.
- S. Information on the availability of, and procedures for obtaining, Certified Nurse Midwife and Certified Nurse Practitioner services, pursuant to Section 6.7.4.14, Nurse Midwife and Nurse Practitioner Services.
- T. Information on the availability of transitional Medi-Cal eligibility and how the Member may apply for this program. Contractor shall include this information, with all Membership Service Guides sent to Members, **after** the date such information is furnished to Contractor by DHS.
- U. Information on how to access State resources for investigation and resolution of Member complaints, including the DHS’ Medi-Cal Managed Care Ombudsman toll-free telephone number (1-888-452-8609) and the DOC HMO Consumer Service toll free telephone number (1-800-400-0815).
- V. **Information** concerning the provision and availability of services covered under the CCS program from providers outside Contractor’s provider network, and how to access these services.
- W. An explanation of the expedited disenrollment process for children receiving services under the Foster Care or Adoption Assistance Programs; Members with special health care needs, including, but not limited to major organ transplants; and Members already enrolled in another Medi-Cal, Medicare, or commercial managed care plan.
- X. Information on how to obtain Minor Consent Services through Contractor’s plan, and an explanation of those services.

- Y. A brief explanation on how to use the Fee-for-Service system when Medi-Cal covered services are excluded or limited under this Contract, and how to obtain additional information.
- Z. An explanation of an American Indian Member's right to access Indian Health Service facilities and to disenroll from Contractor's plan at any time, without cause.
- AA. Subsections S through Z above, except Subsection T, shall be included in Contractor's Membership Services Guide by April 1, 1999, or upon the next reprinting of Contractor's Membership Services Guide, whichever is sooner.

- 2 6 In commercial and local initiative contracts, amend Article VI, SCOPE OF WORK, by renumbering Section 6.10.1, Civil Rights Act of 1964 as 6.10.2 and add a new 6.10.1 General Requirement, to read:

~~6.10.1~~ 6.10.1 General Requirement

The Contractor will monitor, evaluate, and take effective action to address any needed improvement in the delivery of culturally and linguistically appropriate services. The Contractor will be accountable for the quality of health care delivered, whether preventive, primary, specialty, emergency or ancillary care services regardless of the number of contracting or subcontracting layers between the Contractor and the individual practitioner delivering care to the Member.

27. In commercial and local initiative contracts, amend Article VI, SCOPE OF WORK, by adding a new Section 6.10.1.1, Written Description, to read:

6.10.1.1 Written Description

The Contractor will implement and maintain a written description of its Cultural and Linguistic Services, which will include the following;

- A. An organizational commitment to deliver culturally and linguistically appropriate health care services.
- B. Goals and objectives which are evaluated and updated annually.
- C. A timetable for implementation and accomplishment of the goals and objectives

- D. An Organizational chart showing the key persons responsible for cultural and linguistic services and activities.
- E. The committees with cultural and linguistic responsibility and provision for support staff, including reporting relationships.
- F. Qualifications of staff responsible for cultural and linguistic services and activities, including appropriate education, experience and training.

28. **In commercial and local initiative contracts, amend Article VI, SCOPE OF WORK, by renumbering Section 6.10.1, Civil Rights Act of 1964 as 6.10.2, and amend to read:**

6.10.2 Civil Rights Act of 1964

The Contractor will ensure compliance with Title 6 of the Civil Rights Act of 1964 (42 U.S.C. Section 2000d, 45 C.F.R. Part 80) which prohibits recipients of federal financial assistance from discriminating against persons based on race, color, or national origin.

The Contractor will provide 24 hour access to interpreter services for all Members at primary care and pharmacy ~~all provider sites~~ within the Contractor's network either through telephone language services or interpreters.

29. **In commercial and local initiative contracts, amend Article VI, SCOPE OF WORK, by renumbering 6.10.2 Linguistic Services to 6.10.3 and, amend to read:**

6.10.3 'Linguistic Services

The Contractor will provide linguistic services to a population group of mandatory Medi-Cal eligibles residing in the proposed Service Area who indicate their primary language as other than English, and who meet a numeric threshold of 3,000, or a population group of mandatory Medi-Cal eligibles residing in the proposed Service Area who indicate their primary language as other than English and who meet the concentration standards of 1,000 in a single ZIP code or 1,500 in two contiguous ZIP codes.

The Contractor will provide the following services to those Member groups at these key points of contact:

- A. Key Points of Contact

- D. An Organizational chart showing the key persons responsible for cultural and linguistic services and activities.
- E. The committees with cultural and linguistic responsibility and provision for support staff, including reortinn relationships.
- F. Qualifications of staff responsible for cultural and linguistic services and activities, including appropriate education, experience and trainina.

28. **In commercial and local initiative contracts, amend Article VI, SCOPE OF WORK, by renumbering Section 6.10.1, Civil Rights Act of 1964 as 6.T0.2, and amend to read:**

6.10.2 Civil Rights Act of 1964

The Contractor will ensure compliance with Title 6 of the Civil Rights Act of 1964 (42 U.S.C. Section 2000d, 45 C.F.R. Part 80) which prohibits recipients of federal financial assistance from discriminating against persons based on race, color, or national origin.

The Contractor will provide 24 hour access to interpreter services for all Members at ~~all outpatient all provider~~ sites within the Contractor's network either through telephone language services or interpreters.

29. **In commercial and local initiative contracts, amend Article VI, SCOPE OF WORK, by renumbering 6.10.2 Linguistic Services to 6.10.3 and, amend to read:**

6.10.3 Linguistic Services

The Contractor will provide linguistic services to a population group of mandatory Medi-Cal eligibles residing in the proposed Service Area who indicate their primary language as other than English, and who meet a numeric threshold of 3,000, or a population group of mandatory Medi-Cal eligibles residing in the proposed Service Area who indicate their primary language as other than English and who meet the concentration standards of 1,000 in a single ZIP code or 1,500 in two contiguous ZIP codes.

The Contractor will provide the following services to those Member groups at these key points of contact:

- A. Key Points of Contact

1. Medical: Advice and Urgent Care telephone, face to face outpatient Encounters with health care providers including pharmacists.
2. Non-medical: Membership services, orientations, and when scheduling appointments.

B. Types of Services

1. Interpreters or bilingual providers and provider staff.
2. ~~Translated signage.~~
- ~~32.~~ 3. Translated written informing materials, including but not limited to the Member Services Guide, enrollee information, welcome packets, and marketing information.
43. Referrals to culturally and linguistically appropriate community services programs.

30. In commercial and local initiative contracts, amend Article VI, SCOPE OF WORK, by renumbering Section 6.10.3, Linguistic Capacity of Employees as Section 6.10.4, to read:

6.10.4 Linguistic Capacity of Employees

The Contractor will assess, identify and report, the linguistic capability of interpreters or bilingual employed and contracted staff (clinical and non-clinical).

31. In commercial and local initiative contracts, amend Article VI, SCOPE OF WORK, by renumbering Section 6.10.4, Subcontracts as 6.10.5 Subcontracts, and amended to read:

6.10.5 Subcontracts

The Contractor will document in the Subcontracts with Traditional and Safety-Net providers how the interpreter linguistic services to will be provided to Members, and the individuals who will provide the linguistic services to Members within the proposed Service Area.

32. **In commercial and local initiative contracts, amend Article VI, SCOPE OF WORK, by renumbering Section 6.10.5, Community Advisory Committee as Section 6.10.6, Community Advisory Committee, and amended to read:**

6.10.5 Community Advisory Committee

Contractor will implement and maintain community linkages through the formation of a Community Advisory Committee (CAC) with demonstrated participation of consumers, community advocates, and Traditional and Safety-Net providers. The Contractor will ensure that the committee responsibilities include advisement on educational and operational issues affecting cultural groups who may or may not speak a primary language other than English and cultural competency.

33. **In commercial and local initiative contracts, amend Article VI, SCOPE OF WORK, by renumbering Section 6.10.6, Cultural and Linguistic Services Plan as Section 6.10.7, Cultural and Linguistic Services Program -Written Description**

6.10.67 Cultural and Linguistic Services Proqram-Written Description

Contractor shall ensure that a group needs assessment of Members is completed, ~~between twelve (12) and eighteen (18) months after the commencement of operations under this Contract~~ This group needs assessment shall be conducted in conjunction with the health education group needs assessment, described in Section 6.7.7.7, (Group Needs Assessment), and shall include identification of linguistic a&&r&needs of the groups, which speak a primary language other than English-and of all cultural groups within the service area.

The findings of the assessment shall be ~~submitted to DHS maintained in the form of a plan as~~ a proaram description entitled "Cultural and Linguistic Services Plan" "Program" ~~between twelve (12) and eighteen (18) months after commencement of operations under this Contract.~~ In the plan proaram description, Contractor shall summarize the methodology and findings of the group needs assessment of the cultural and linguistic needs of non-English speaking groups, as well as the cultural needs of all plan Members, and outline the proposed services to be implemented to address ~~the findings of cultural and linguistic needs of non-English speaking Members,~~ the timeline for implementation with milestones, and the responsible individual.

~~Contractor shall ensure implementation of the Cultural and Linguistic Services Plan between twelve (12) and eighteen (18) months after the commencement of operations under this Contract. Contractor shall also identify the individual with overall responsibility for the activities to be conducted under the plan. DHS approval of the plan is required prior to its implementation.~~

34. In commercial and local initiative contract, amend Article VI, SCOPE OF WORK, by deleting Section 6.10.7, Implementation Plan in its entirety.

~~6.10.7 Implementation Plan~~

~~The Contractor will be required to submit for DHS approval a workplan for achieving compliance with the full scope of cultural and linguistic services requirements within a specified time. If a Contractor does not comply with all of the Cultural and Linguistic Services requirements in Sections 6.10 through 6.10.9 upon implementation of the Contract, the Contractor will comply with the threshold requirements in Sections 6.10.1, 6.10.2, 6.10.2 A through 6.10.2 B(1), 6.10.2 B(4), 6.10.4 and 6.10.7 for the provision of oral interpretation services to the groups who speak a primary language other than English meeting the thresholds.~~

~~The Contractor will submit for DHS approval a proposed workplan for meeting the full scope of requirements. In the workplan, the Contractor will include a description of the required activities, a timeline with milestones, and identify the individuals responsible for the activity. The Contractor will identify the individual with overall responsibility and ensure that the activities identified in the workplan approved by DHS will be fully operational within six months of the beginning of year two of operations under the Contract. The Contractor will entitle the workplan "Cultural and Linguistic Services: Proposed Activities".~~

35. In commercial and local initiative contracts, amend Article VI, SCOPE OF WORK, by amending Section 6.10.8, Standards and Performance Requirements, to read and rename as Section 6.10.8, Program Implementation and Evaluation

6.10.8 Program Implementation and Evaluation

Contractor will develop and implement standards and performance requirements for the provision of linguistic services, and will monitor policies and procedures for assessing the performance of the individuals who provide linguistic services as well as for overall

monitorina and evaluation of the Cultural and Linguistic Services Program.

36. **In commercial and local initiative contracts, amend Article VI, SCOPE OF WORK, by deleting Section 6.10.9, Interpreter Coordination, in its entirety.**

6.10.9 Interpreter Coordination

~~Contractor will develop and implement standards for appointment scheduling and a system for coordinating interpreters, to ensure continuity in the assignment of interpreters to Members when follow up care is required.~~

1. In Commercial and Local Initiative contracts, amend ARTICLE III TERMS AND CONDITIONS, Section 3.7. Compliance with Protocols to read:

3.7 COMPLIANCE WITH PROTOCOLS

Contractor shall develop the MOU's, protocols and procedures specified in this Contract and shall comply with them. Protocols and Procedures shall be kept at the Plan's offices and shall be available for review by DHS. Protocols and Procedures shall be submitted to DHS upon request. ~~within 30 days of their approval by DHS~~ All -revisions thereof will be ~~approved by DHS and~~ implemented by the Contractor in a timely manner. The Contractor is responsible to assure that providers in the network are sufficiently trained to implement the Protocols and Procedures. The Contractor is responsible to assure that providers in the network are notified of changes to Protocols and Procedures in a manner sufficient to ensure the timely implementation of changes. ~~within 30 days of such approval. The Contractor will not implement protocols, procedures or revisions thereof prior to approval by DHS.~~

2. In Commercial and Local Initiative contracts, amend ARTICLE III TERMS AND CONDITIONS, Section 3.41 Cost Avoidance and Post-Payment Recover of other Health Coverage Sources to read:

4.41 COST AVOIDANCE AND POST-PAYMENT RECOVERY OF OTHER HEALTH COVERAGE SOURCES

- A. Contractor shall Cost Avoid or make a Post-Payment Recovery for the reasonable value of services paid for by Contractor and rendered to a Member whenever a Member's OHCS covers the same services, either fully or partially, However, in no event shall Contractor Cost Avoid or seek Post-Payment Recovery for the reasonable value of services from a TPTL action or make a claim against the estates of deceased Members.
- B. All monies recovered by Contractor are retained by Contractor.
- C. Contractor shall coordinate benefits with other coverage programs or entitlements, recognizing the OHCS as primary and the Medi-Cal program as the payor of last resort.
- D. Cost Avoidance
 - ~~1.~~ If Contractor reimburses the provider on a fee-for-service basis, Contractor shall not pay claims for services provided to a Member whose Medi-Cal eligibility record indicates third party coverage, designated by a Other Health Coverage (OHC) code or Medicare coverage, without proof that the provider has first exhausted all sources of other payments. Contractor shall have written procedures implementing this r e q u i r e m e n t . : ~~DHS for review and comment.~~
 - 2. Proof of third party billing is not required prior to payment for services provided to Members with OHC codes A, M, X, Y, or Z.
- E. Post-Payment Recovery
 - 1. If Contractor reimburses the provider on a fee-for-service basis, Contractor shall pay the provider's claim and then seek to recover the cost of the claim by billing the liable third parties:

- a. For services provided to Members with OHC codes A, M, X, Y, or Z;
 - b. For services defined by DHS as prenatal or preventive pediatric services; or
 - b. In child-support enforcement cases, identifiable by Contractor. If Contractor does not have access to sufficient information to determine whether or not the OHC coverage is the result of a child enforcement case, Contractor shall follow the procedures for Cost Avoidance.
2. In instances where Contractor does not reimburse the provider on a fee-for-service basis, Contractor shall pay for services provided to a Member whose eligibility record indicates third party coverage, designated by a OHC code or Medicare coverage, and then shall bill the liable third parties for the cost of actual services rendered.
 3. Contractor shall also bill the liable third parties for the cost of services provided to Members who are retroactively identified by Contractor or DHS as having OHC.
 4. Contractor shall have written procedures implementing the above requirements. 1
~~procedures to DHS for review and comment.~~
- F. Contractor shall initiate a Disenrollment for all Members whose eligibility record indicates OHC codes K, C, P, or F, within three (3) **State working** days after Contractor becomes aware of the OHC code. Until the Member is disenrolled, Contractor shall Cost Avoid or seek Post-Payment Recovery as specified in subsections D and E above.
- G. Reporting Requirements
1. Contractor shall submit monthly reports to DHS, in a format prescribed by DHS, displaying claims counts and dollar amounts of costs avoided and the amount of Post-Payment Recoveries, by aid category, as well as the amount of outstanding recovery claims (accounts receivable) by age of account. The report shall display separate claim counts and dollar amounts for Medicare Part A and Part B. Reports shall be sent to the Department of Health Services, Third

Party Liability Branch, Cost Avoidance Unit, P.O. Box 2471,
Sacramento, CA 95812-2471.

2. When Contractor identifies OHC unknown to DHS, Contractor shall report this information to DHS within ten (10) days of discovery in automated format as prescribed by DHS. This information shall be sent to the Department of Health Services, Third Party Liability Branch, Health Identification Unit, P.O. Box 2471, Sacramento, CA 95812-2471.
2. Contractor shall demonstrate to DHS that where Contractor does not Cost Avoid or perform Post-Payment Recovery, that the aggregate cost of this activity exceeds the total revenues Contractor projects it would receive from such activity.

3. **In Commercial and Local Initiative contracts, amend ARTICLE III TERMS AND CONDITIONS, Section 3.43 Obtaining DHS Approval to read:**

3.43 OBTAINING DHS APPROVAL

Contractor shall obtain written approval from DHS, as provided in Section 4.7, Approval Process, prior to implementing or using any of the following, including revisions to any of the items listed:

- A. Providers of Covered Services, except for providers of seldom used or unusual services as determined by DHS.
- B. Facilities.
- C. Marketing activities.
- D. Marketing materials, promotional materials, and public information releases relating to performance under this Contract, Member service guides; Member newsletters; and provider claim forms unique to the Contract.
- E. Member Grievance procedure.
- F. Member Disenrollment procedure.
- G. Grievance forms.
- H. Any other protocol, policy or procedure otherwise requiring approval under this Contract.
- I. Tranylcypromine Sulfate

4. **In Commercial and Local Initiative contracts, amend ARTICLE VI SCOPE OF WORK, Section 655.2 Review Procedures to read:**

6.5.5.2 **Review Procedures**

The Contractor will ensure that its Facility review procedures ~~will be~~
C o m p l y w i t h a l l
of DHS requirements which include the following:

- A. Front office procedures including:
 - 1. Telephone access, triage/advice.
 - 2. Appointment scheduling.
 - 3. Missed appointment and follow-up.
 - 4. Referral appointment and follow-up.
 - 5. Referral (consultation) reports, lab and X-ray follow-up
- B. Fire and disaster plan.
- C. Infection control.
- D. Handling of bio-hazardous wastes/
- E. Health education.
- F. Medical emergencies.
- G. Pharmacy policies (including handling of sample drugs).
- H. Medical Records storage and filing.
- I. Medical Records documentation.
- J. Grievance.
- K. Laboratory services.
- L. Radiological services.

M. Preventive services for children, adults and pregnant women.

N. Facility access for physically disabled individuals.

O. Informed consent procedures.

5. **In Commercial and Local Initiative contracts, amend ARTICLE VI SCOPE OF WORK, Section 6.5.7.8 Sensitive Services to read:**

6.5.7.8 Sensitive Services

Contractor shall implement and maintain procedures to ensure confidentiality and ready access to Sensitive Services for all Members, including minors. Members shall be able to access Sensitive Services in a timely manner and without barriers such as Prior Authorization requirements. Access to abortion services for Members who are minors shall be subject to applicable State and federal law.

The Contractor will develop, implement and maintain policies and procedures for the treatment of HIV infection and AIDS. ~~These policies and procedures will be submitted to DHS no later than October 1, 1997. The Contractor will submit any changes in these policies and procedures to DHS at least 30 days prior to their implementation.~~

6. Commercial and Local Initiative contracts, amend ARTICLE VI SCOPE OF WORK, Section 6.5.7.8 Sensitive Services to read:

6.7.3.5 Dental

Dental services are not covered under this Contract. Contractor shall perform dental screening for all Members as a part of the initial health assessment and refer Members to Medi-Cal dental providers. Dental screenings for Members under twenty-one (21) years of age shall be performed in accordance with the most recent recommendations of the American Academy of Pediatrics, as part of the initial health assessment. Contractor shall ensure referrals to dental providers.

Services related to dental services that are covered medical services and are not provided by dentists or dental anesthetists, are the responsibility of Contractor. Covered medical services include: prescription drugs, laboratory services, pre-admission physical examinations required for admission to a facility, anesthesia services, out-patient surgical center services and in-patient hospitalization services required for a dental procedure. Contractor may require Prior Authorization for medical services required in support of dental procedures.

Contractor shall develop referral and Prior Authorization policies and procedures to implement the above requirements. Contractor shall ~~develop, implement and maintain~~ submit these policies and procedures, ~~to DHS for review and approval.~~

7. **In Commercial and Local Initiative contracts, include in the Definitions as follows:**

- 13. **Policy Statement** means a detailed goal statement in which the Contractor commits to meet all aspects of this Contact.
- J3. **Procedures** means a detailed description of how the Contractor and its designees will achieve the goal. It will contain details of systems, processes, and lines of communication integral to achieving the policy.
- K3. **Protocols** means a written plan of delivery of services and must identify how the services are delivered for standard, consistent care to members.