

**Exhibit A
SCOPE OF WORK**

1. Service Overview

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

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

2. Service Location

The services shall be performed at all contracting and participating facilities of Contractor or through Telehealth, as appropriate.

3. Service Hours

The services shall be provided on a 24-hour, seven (7) days a week basis.

4. Project Representatives

A. The project representatives during the term of this agreement will be:

<p>Department of Health Care Services</p> <p>Managed Care Operations Division</p> <p>Attention: Chief, Managed Care Systems and Support Branch</p> <p>Telephone: (916) 449-5100</p> <p>Fax: (916) 449-5090</p>	
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B. Direct all inquiries to:

<p>Department of Health Care Services</p> <p>Managed Care Operations Division</p> <p>Attention: Contracting Officer</p> <p>1501 Capitol Avenue, Suite 71.4001</p> <p>MS 4407</p>	
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P.O. Box Number 997413 Sacramento, CA 95899-7413 Telephone: (916) 449-5000 Fax: (916) 449-5005	
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- C. Either party may make changes to the information above by giving written notice to the other party. Said changes shall not require an amendment to this agreement.

**Exhibit A, Attachment 1
ORGANIZATION AND ADMINISTRATION OF THE PLAN**

1. Legal Capacity

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

2. Key Personnel (Disclosure Form)

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

- 1) Any person or corporation having 5% or more ownership or controlling interest in the Contractor.
- 2) Any director, officer, partner, trustee, or employee of the Contractor.
- 3) Any member of the immediate family of any person designated in 1) or 2) above.

B. Comply with Title 42 Code of Federal Regulations (CFR) 455.104 (Disclosure by providers and fiscal agents: Information on ownership and control), 42 CFR 455.105 (Disclosure by providers: Information related to business transactions), 42 CFR 455.106 and 42 CFR 438.610 (Prohibited Affiliations with Individuals Debarred by Federal Agencies).

3. Conflict of Interest – Current And Former State Employees

A. This Contract shall be governed by the Conflict of Interest provisions of Title 22 CCR Sections 53874 and 53600, and 42 CFR 438.3(f)(2).

B. Contractor shall not utilize in the performance of this Contract any State officer or employee in the State civil service or other appointed State official unless the employment, activity, or enterprise is required as a condition of the officer's or employee's regular State employment. For purposes of this subsection (B) only, employee in the State civil service is defined to be any person legally holding a permanent appointed or intermittent position in the State civil service.

4. Contract Performance

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

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ORGANIZATION AND ADMINISTRATION OF THE PLAN**

- A. The organization has an accountable governing body.
- B. This Contract is a high priority and that the Contractor is committed to supplying any necessary resources to assure full performance of the Contract.
- C. If the Contractor is a subsidiary organization, the attestation of the parent organization that this Contract will be a high priority to the parent organization. The parent organization is committed to supplying any necessary resources to assure full performance of the Contract.
- D. Staffing in medical and other health services, and in fiscal and administrative services sufficient to result in the effective conduct of the plan's business.
- E. Written procedures for the conduct of the business of the plan, including the provision of health care services, so as to provide effective controls.

5. Medical Decisions

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

6. Medical Director

Contractor shall maintain a full time physician as medical director pursuant to Title 22 CCR Section 53857 whose responsibilities shall include, but not be limited to, the following:

- A. Ensuring that medical decisions are:
 - 1) Rendered by qualified medical personnel.
 - 2) Are not influenced by fiscal or administrative management considerations.
- B. Ensuring that the medical care provided meets the standards for acceptable medical care.
- C. Ensuring that medical protocols and rules of conduct for plan medical personnel are followed.
- D. Developing and implementing medical policy.
- E. Resolving Grievances related to medical quality of care.
- F. Direct involvement in the implementation of Quality Improvement activities.

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ORGANIZATION AND ADMINISTRATION OF THE PLAN**

- G. Actively participating in the functioning of Grievance and Appeal procedures.

7. Medical Director Changes

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

8. Administrative Duties/Responsibilities

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

- A. Member and enrollment reporting systems as specified in Exhibit A, Attachment 3, Management Information System, and, Exhibit A, Attachment 13, Member Services, and Exhibit A, Attachment 14, Member Grievance and Appeal System.
- B. A Member Grievance and Appeal procedure, as specified in Exhibit A, Attachment 14, Member Grievance and Appeal System.
- C. Data reporting capabilities sufficient to provide necessary and timely reports to DHCS, as required by Exhibit A, Attachment 3, Management Information System.
- D. Financial records and books of account maintained on the accrual basis, in accordance with Generally Accepted Accounting Principles, which fully disclose the disposition of all Medi-Cal program funds received, as specified in Exhibit A, Attachment 2, Financial Information.
- E. Claims processing capabilities as described in Exhibit A, Attachment 8, Provider Compensation Arrangements.

9. Member Representation

Contractor shall ensure that Medi-Cal Members, including Seniors and Persons with Disabilities (SPD), persons with chronic conditions (such as asthma, diabetes, congestive heart failure), and Members who use Managed Long Term Services and Supports (MLTSS) or their representatives are included and participate in establishing public policy within the Contractor's advisory committee or other similar committee or group.

10. Sensitivity Training

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

**Exhibit A, Attachment 2
FINANCIAL INFORMATION**

1. Financial Viability/Standards Compliance

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

A. Tangible Net Equity (TNE).

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

B. Administrative Costs.

Contractor's Administrative Costs shall not exceed the standards as established under Title 22 CCR Section 53864(b).

C. Standards of Organization and Financial Soundness.

Contractor shall maintain an organizational structure sufficient to conduct the proposed operations and ensure that its financial resources are sufficient for sound business operations in accordance with Title 28, CCR, Sections 1300.67.3, 1300.75.1, 1300.76.3, 1300.77.1, 1300.77.2, 1300.77.3, 1300.77.4, and Title 22 CCR Sections 53851, 53863, and 53864.

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

- 1) Contractor shall maintain a working capital ratio of at least 1:1; or
- 2) Contractor shall demonstrate to DHCS that Contractor is now meeting financial obligations on a timely basis and has been doing so for at least the preceding two years; or
- 3) Contractor shall provide evidence that sufficient noncurrent assets, which are readily convertible to cash, are available to achieve an equivalent working capital ratio of 1:1, if the noncurrent assets are considered current.

2. Financial Audit Reports

Contractor shall ensure that an annual audit is performed according to Welfare and Institutions Code, Section 14459. Certified Public Accountant's audited Financial Statements shall be submitted to DHCS no later than 120 calendar days after the close of Contractor's fiscal year. Combined Financial Statements shall be prepared to show the financial position of the overall related health care delivery system when delivery of care or other services is dependent upon Affiliates. Financial Statements shall be presented in a form that clearly shows the financial position of Contractor separately from the combined totals. Inter-entity transactions and profits shall be eliminated if combined statements are

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FINANCIAL INFORMATION**

prepared. If an independent accountant decides that preparation of combined statements is inappropriate, Contractor shall have separate certified Financial Statements prepared for each entity.

- A. The independent accountant shall state in writing the reasons for not preparing combined Financial Statements.
- B. Contractor shall provide supplemental schedules that clearly reflect all inter-entity transactions and eliminations necessary to enable DHCS to analyze the overall financial status of the entire health care delivery system.
 - 1) In addition to annual certified Financial Statements, Contractor shall complete the State Department of Managed Health Care (DMHC) required financial reporting forms. The Certified Public Accountant's audited Financial Statements and DMHC required financial reporting forms shall be submitted to DHCS no later than 120 calendar days after the close of Contractor's Fiscal Year.
 - 2) If Contractor is a public entity or a political subdivision of the State and a county grand jury conducts Contractor's financial audits, Contractor shall submit its financial statement within 180 calendar days after the close of Contractor's Fiscal Year in accordance with Health and Safety Code, Section 1384.
 - 3) Contractor shall submit to DHCS within 45 calendar days after the close of Contractor's fiscal quarter, quarterly financial reports required by Title 22 CCR Section 53862(b)(1). The required quarterly financial reports shall be prepared on DMHC required financial reporting forms and shall include, at a minimum, the following reports/schedules:
 - a) Jurat.
 - b) Report 1A and 1B: Balance Sheet.
 - c) Report 2: Statement of Revenue, Expenses, and Net Worth.
 - d) Statement of Cash Flow, prepared in accordance with Financial Accounting Standards Board Statement Number 95 (This statement is prepared in lieu of Report #3: Statement of Changes in Financial Position for Generally Accepted Accounting Principles (GAAP) compliance.)
 - e) Report 4: Enrollment and Utilization Table.
 - f) Schedule F: Unpaid Claims Analysis.

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- g) Appropriate footnote disclosures in accordance with GAAP.
 - h) Schedule H: Aging Of All Claims.
- C. Contractor shall authorize its independent accountant to allow DHCS designated representatives or agents, upon written request, to inspect any and all working papers related to the preparation of the audit report.
- D. Contractor shall submit to DHCS all financial reports relevant to Affiliates as specified in Title 22 CCR Section 53862(c)(4).
- E. Contractor shall submit to DHCS copies of any financial reports submitted to other public or private organizations as specified in Title 22 CCR Section 53862(c)(5).

3. All Financial Statements

- A. Contractor shall submit Medi-Cal financial reports, including financial information for Adult Expansion Members. Contractor shall submit financial reports to DHCS no later than 120 calendar days after the close of the following periods:
- 1) January 1, 2014 to June 30, 2015 (18 months); and
 - 2) July 1, 2015 to June 30, 2016 (12 months)
- B. Contractor shall prepare all financial information requested by DHCS in accordance with Generally Accepted Accounting Principles. Contractor's financial reports shall be prepared in the DMHC required financial reporting format. All financial reports shall include the following reports/schedules:
- 1) Report 2: Statement of Revenue, Expenses, and Net Worth; and
 - 2) Report 4: Enrollment and Utilization Table.
- C. Where appropriate, this Contract refers to the Knox-Keene Health Care Service Plan Act of 1975 rules in Title 28, CCR Section 1300.51 et. seq. Contractor shall submit information based on current operations. Contractor, as well as Subcontractors, shall submit financial information consistent with DMHC filing requirements unless otherwise specified by DHCS.

4. Monthly Financial Statements

If Contractor and/or Subcontractor is required to file monthly Financial Statements with DMHC, Contractor and/or Subcontractor shall file an exact copy of the monthly Financial Statements with DHCS. Contractor and/or Subcontractor shall submit monthly financial statements to the DHCS upon request, if deemed

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necessary, to monitor the Contractor and/or Subcontractor's financial viability.

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

- A. Jurat.
- B. Report 1A and 1B: Balance Sheet
- C. Report 2: Statement of Revenue, Expenses, and Net Worth.
- D. Statement of Cash Flow, prepared in accordance with Financial Accounting Standards Board Statement Number 95 (This statement is prepared in lieu of Report #3: Statement of Changes in Financial Position for Generally Accepted Accounting Principles (GAAP) compliance.)
- E. Report 4: Enrollment and Utilization Table.
- F. Schedule F: Unpaid Claims Analysis.
- G. Appropriate footnote disclosures in accordance with GAAP.
- H. Schedule H: Aging of All Claims.

5. Quarterly Financial Statements

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

- A. Jurat.
- B. Report 1A and 1B: Balance Sheet
- C. Report 2: Statement of Revenue, Expenses, and Net Worth.
- D. Statement of Cash Flow, prepared in accordance with Financial Accounting Standards Board Statement Number 95 (This statement is prepared in lieu of Report #3: Statement of Changes in Financial Position for Generally Accepted Accounting Principles (GAAP) compliance.)
- E. Report 4: Enrollment and Utilization Table.
- F. Schedule F: Unpaid Claims Analysis.

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- G. Appropriate footnote disclosures in accordance with GAAP.
- H. Schedule H: Aging of All Claims.

6. Annual Financial Statements

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

- A. Jurat.
- B. Report 1A and 1B: Balance Sheet
- C. Report 2: Statement of Revenue, Expenses, and Net Worth.
- D. Statement of Cash Flow, prepared in accordance with Financial Accounting Standards Board Statement Number 95 (This statement is prepared in lieu of Report #3: Statement of Changes in Financial Position for Generally Accepted Accounting Principles (GAAP) compliance.)
- E. Report 4: Enrollment and Utilization Table.
- F. Schedule F: Unpaid Claims Analysis.
- G. Appropriate footnote disclosures in accordance with GAAP.
- H. Schedule H: Aging of All Claims.

7. Medi-Cal Line of Business Financial Statements

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

- A. Report 2: Statement of Revenue, Expenses, and Net Worth by County.
- B. Report 4: Enrollment and Utilization Table by County.

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

Contractor shall submit the Medi-Cal line of business financial statements within the same time frame as indicated for each required financial statement with the exception of the annual financial statement. The

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annual Medi-Cal line of business Financial Statements shall be submitted to DHCS no later than 120 calendar days after the close of the State fiscal year.

8. Annual Forecasts

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

- A. Report 2: Statement of Revenue, Expenses, and Net Worth by County. (Medi-Cal line of business)
- B. Report 4: Enrollment and Utilization Table by County. (Medi-Cal line of business)
- C. TNE. (All lines of business)
- D. A detailed explanation of all underlying assumptions used to develop the forecast.

9. Compliance with Audit Requirements

Contractor shall cooperate with DHCS' audits. Such audits may be waived upon submission of the financial audit for the same period conducted by DMHC pursuant to Health and Safety Code, Section 1382.

10. Submittal of Financial Information

- A. Contractor shall prepare financial information requested in accordance with GAAP. Where Financial Statements and projections/forecasts are requested, these statements and projections/forecasts should be prepared in accordance with the 1989 HMO Financial Report of Affairs and Conditions Format. Where appropriate, reference has been made to the Knox-Keene Health Care Service Plan Act of 1975 rules found under Title 28, CCR, Section 1300.51 et. seq. Information submitted shall be based on current operations. Contractor and/or Subcontractors shall submit financial information consistent with filing requirements of the DMHC unless otherwise specified by DHCS.
- B. Contractor shall prepare and submit a stand-alone Medi-Cal line of business income statement for each financial reporting period required. This income statement shall be prepared in DMHC required financial reporting format.

11. Fiscal Viability of Network Providers and Subcontractors

Contractor shall maintain a system to evaluate and monitor the financial viability

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FINANCIAL INFORMATION**

of Network Providers and Subcontractors that accept financial risk for the provision of Covered Services including, but not limited to, Medi-Cal Managed Care Health Plans, independent Physician/Provider associations, medical groups, hospitals, risk-bearing organizations as defined in Title 28 CCR Section 1300.75.4(b), Federally Qualified Health Centers (FQHC) and other clinics.

12. Contractor's Obligations

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

**Exhibit A, Attachment 3
MANAGEMENT INFORMATION SYSTEM (MIS)**

1. Management Information System (MIS) Capability

- A. Contractor's Management and Information System (MIS) shall be fully compliant with 42 CFR section 438.242 requirements and shall have the capability to capture, edit, and utilize various data elements for both internal management use as well as to meet the data quality and timeliness requirements of DHCS's Encounter Data submission. All data related to this Contract shall be available to DHCS and to the Centers for Medicare and Medicaid Services (CMS) upon request. Contractor shall have and maintain a MIS that provides, at a minimum:
- 1) All Medi-Cal eligibility data,
 - 2) Information of Members enrolled in Contractor's plan,
 - 3) Provider claims status and payment data,
 - 4) Health care services delivery Encounter Data,
 - 5) Provider Network information,
 - 6) Program Data,
 - 7) Financial information as specified in Exhibit A, Attachment 1, Provision 8. Administrative Duties/Responsibilities, and
 - 8) Member and Member's authorized representative Alternative Format Selection(s) (AFS).
- B. Contractor's MIS shall have processes that support the interactions between Financial, Member/Eligibility; Provider; Encounter Claims; Quality Management/Quality Improvement/Utilization; and Report Generation subsystems. The interactions of the subsystems must be compatible, efficient and successful.
- C. Contractor shall implement and maintain a publicly accessible, standards-based Patient Access Application Programming Interface (API), and a provider directory API, as described in 42 CFR sections 431.60 and 431.70, and in APL 22-026. Contractor must operate the API in the manner specified in 45 CFR section 170.215 and include information per 42 CFR section 438.242(b)(5) and (6).

2. Encounter Data Reporting

- A. Contractor shall maintain a MIS that collects and reports Encounter Data to DHCS, including allowed amounts and paid amounts as required, in compliance with 42 CFR section 438.242, and pursuant to applicable

**Exhibit A, Attachment 3
MANAGEMENT INFORMATION SYSTEM (MIS)**

DHCS All Plan Letters (APL).

- B. Contractor shall implement policies and procedures for ensuring complete, accurate, reasonable, and timely submission of Encounter Data to DHCS for all items and services furnished to a Member under this Contract, whether directly or through Network Provider Agreements or Subcontractor Agreements. Encounter Data shall be submitted on at least a monthly basis in a form and manner specified by DHCS.
- C. Contractor shall require Subcontractors, Network Providers, and Out-of-Network Providers to submit claims and Encounter Data to Contractor to meet its administrative functions and the requirements set forth in this Section. Contractor shall have in place mechanisms, including edit and reporting systems sufficient to assure Encounter Data is complete, accurate, and timely prior to submission to DHCS. Contractor shall ensure the completeness, accuracy, and timeliness of all Network Provider, Subcontractor, and Out-of-Network Provider Encounter Data regardless of whether Subcontractor, Network Provider, or Out-of-Network Provider is reimbursed on a Fee-For-Service (FFS) or capitated basis.
- D. Contractor shall submit complete, accurate, reasonable, and timely Encounter Data within six (6) business days of the end of each month following the month of payment, under this Contract or as otherwise agreed upon by DHCS, and in the format specified by DHCS.
- E. DHCS shall review and validate the Encounter Data for completeness, accuracy, and timeliness.
- F. If DHCS finds deficiencies regarding the completeness, accuracy, and timeliness of the Encounter Data, DHCS may notify Contractor in writing of the deficiency and request correction and resubmission of the relevant Encounter Data. Contractor shall ensure that corrected Encounter Data is resubmitted within 15 calendar days of the date of DHCS' notice. Upon Contractor's written request, DHCS may grant an extension for submission of corrected Encounter Data.
- G. Contractor shall ensure all Encounter Data is submitted to DHCS within two (2) months of adjudication of a FFS claim or receipt of a capitated Encounter. Subcontractors, Network Providers, and Out-of-Network Providers must comply with this Provision for submission of Encounter Data to Contractor. All Encounter Data shall be submitted to Contractor no later than 12 months from the date of service.
- H. DHCS or its agent will periodically, but not less frequently than once every three (3) years, conduct an independent audit of the Encounter Data submitted by, or on behalf of, Contractor, In accordance with 42 CFR

**Exhibit A, Attachment 3
MANAGEMENT INFORMATION SYSTEM (MIS)**

438.602(e).

3. MIS/Data Correspondence

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

4. Health Insurance Portability and Accountability Act (HIPAA)

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

5. Participation in the State Drug Rebate Program

- A. Contractor shall participate in the federal and State drug rebate program by including all utilization data for both current and retroactive outpatient drugs in its Encounter Data as necessary to meet federal requirements set forth in 42 USC section 1396r-8(k)(2).
 - 1) Encounter Data for outpatient drugs shall comply with Section 1927(b)(1)(A) of the Social Security Act.
 - 2) All outpatient drug Encounter Data shall include, at a minimum, the total number of units of each dosage form, strength, and package size, by National Drug Code, for each eligible Physician administered drug claim.
- B. Pursuant to 42 CFR 438.3(s), Contractor shall ensure that Encounter Data for outpatient drugs from participants in the federal 340B program contains DHCS-required identifiers to maintain compliance with the requirements of 42 USC 256b(a)(5)(A)(i). Contractor shall also comply with the provisions of W & I Code 14105.46.
- C. Contractor shall assist DHCS in resolving manufacturer rebate disputes due to Provider Network or Encounter Data submissions.

**Exhibit A, Attachment 3
MANAGEMENT INFORMATION SYSTEM (MIS)**

6. Network Data Submissions

Contractor shall maintain a health information system that collects and reports Network data to DHCS in compliance with 42 CFR 438.207, 438.604(a)(5), 438.606, and in accordance with APL 17-005.

- A. Contractor shall ensure the complete, accurate, and timely submission of its Network data to DHCS for all data that represents Contractor's Network, whether directly or through Subcontractor Agreements or Network Provider Agreements. Network data shall be submitted on at least a monthly basis in the form and manner specified by DHCS.
- B. For all data submissions required by 42 CFR 438.604, Contractor shall submit its certification of compliance concurrently with the submission of its data, documentation or information pursuant to 42 CFR 438.606(c). Contractor's certification(s) shall be certified by Contractor's Chief Executive Officer; Chief Financial Officer; or an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer. Contractor's Chief Executive Officer or Chief Financial Officer is solely responsible for the certification.
- C. Contractor shall require all Network Providers and Subcontractors to submit Network data to Contractor to meet its administrative functions and the requirements set forth in this Provision. Contractor shall have in place mechanisms, including edit and reporting systems sufficient to assure Network data is complete, accurate, and timely prior to submission to DHCS. Contractor shall ensure the completeness, accuracy, and timeliness of all Subcontractor and Network Provider data regardless of contracting arrangements.
- D. Contractor shall submit complete, accurate, and timely Network data within ten (10) calendar days following the end of each month under this Contract or as otherwise agreed upon by DHCS, and in the format specified by DHCS. Contractor shall certify all Network data as set forth in 42 CFR 438.606.
- E. DHCS shall review and validate Network data for completeness, accuracy, and timeliness. If DHCS finds deficiencies regarding the completeness, accuracy, and timeliness of the Network data, DHCS may notify Contractor in writing of the deficiency and request correction and resubmission of the relevant data. Contractor shall ensure that corrected Network data is resubmitted within 15 calendar days of the date of the DHCS notice. Upon Contractor's written request, DHCS may grant an extension for submission of corrected Network data.

**Exhibit A, Attachment 3
MANAGEMENT INFORMATION SYSTEM (MIS)**

7. Program Data Reporting

- A. Contractor must maintain a MIS that consumes and transmits Program Data to DHCS in accordance with all applicable DHCS APLs.
- B. Contractor must implement policies and procedures for ensuring the complete, accurate, and timely submission of Program Data to DHCS, as defined in State and federal law, all applicable DHCS APLs, and this Contract, including, but not limited to, all Grievances, Appeals, out-of-Network requests, medical exemption request denial reports and other continuity of care requests, and Primary Care Provider assignments received or determined by Contractor, whether directly or through Subcontractor Agreements or Network Provider Agreements.
- C. Contractor must require all Network Providers, Subcontractors, and Out-of-Network Providers to submit Program Data to Contractor to meet Contractor's administrative functions and the requirements set forth in this Contract. Contractor must have mechanisms, including edit and reporting systems, sufficient to ensure Program Data is complete, accurate, and timely, as defined in State and federal law and all applicable DHCS APLs, prior to submission to DHCS. Contractor must ensure the completeness, accuracy, and timeliness of all Network Provider, Subcontractor, and Out-of-Network Provider Program Data regardless of contracting arrangements.
- D. Contractor must submit complete, accurate, and timely Program Data within ten (10) calendar days following the end of each month, or as mandated through federal law, and in a form and manner specified by DHCS. Contractor must certify all Program Data as set forth in 42 CFR section 438.606. Contractor shall ensure that Network Providers, Subcontractors, and Out-of-Network Providers comply with this Provision for submission of Program Data to Contractor.
- E. DHCS will review and validate Contractor's Program Data for completeness, accuracy, and timeliness.
- F. If DHCS finds deficiencies regarding the completeness, accuracy, or timeliness of Contractor's Program Data and notifies Contractor in writing of the deficiencies and requests correction and resubmission of the relevant Program Data, Contractor must ensure that corrected Program Data is resubmitted within 15 calendar days of the date of DHCS' notice, or as mandated through federal law. Upon Contractor's written request, DHCS may, in its sole discretion, grant an extension for submission of corrected Program Data.

**Exhibit A, Attachment 3
MANAGEMENT INFORMATION SYSTEM (MIS)**

8. Tracking and Submitting Alternative Format Selections (AFS)

- A. Contractor shall have and maintain systems that are able to, at a minimum, perform the following functions:
 - 1) Collect and store Member AFS, as well as the AFS of a Member's authorized representative.
 - 2) Share Member AFS data with DHCS as specified in the Alternative Format Data Process Guide included in APL 22-002.
 - 3) Track Member's authorized representative AFS data and submit to DHCS when requested.
- B. Contractor shall submit all Member AFS data that has been collected in a one-time file upload to the DHCS Alternate Formats database, in the time and manner specified in APL 22-002.
- C. After Contractor's one-time file upload is completed, Contractor shall submit to DHCS all new Member AFS at the time of the Member's request. Submissions shall be submitted online through the AFS application system, or by calling the AFS Helpline at (833) 284-0040.
- D. DHCS will share Member AFS data with Contractor on an ongoing basis. DHCS will send Contractor a weekly AFS file from the DHCS Alternate Formats database. The DHCS weekly file data elements and file path is included in the APL 22-002 AFS Technical Guidance attachment. Contractor must utilize the weekly DHCS AFS file data to update their records and provide Member materials in the requested alternative formats.
- E. Contractor shall submit to DHCS policies and procedures for collecting and sharing AFS data in accordance with the requirements in APL 22-002.

9. Interoperability API System Requirements

- A. In order to ensure Contractor applies the same standards for Encounter Data contained in Exhibit A, Attachment 3, Provision 2, Encounter Data Reporting, to data collected and made available through its API, Contractor must verify that data collected from Network Providers and Subcontractors to be made available through the API is accurate, complete, and timely, and collected in accordance with the oversight and monitoring guidance in APL 22-026. Contractor must make all collected data available to DHCS and CMS, upon request.
- B. Contractor must conduct routine testing and monitoring of its API

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MANAGEMENT INFORMATION SYSTEM (MIS)**

functions, and applying system updates as appropriate, to ensure that the API is compliant and functional.

- C. Contractor may deny or discontinue any third-party application connection to its API if Contractor determines, that continued access presents an unacceptable level of risk to the security of protected health information on its systems. Contractor's determination shall be made in accordance with the guidance provided in APL 22-026.

**Exhibit A, Attachment 4
QUALITY IMPROVEMENT SYSTEM**

1. General Requirement

Contractor shall implement an effective Quality Improvement System (QIS) in accordance with the standards set forth in Title 28, CCR, Section 1300.70 and 42 CFR 438.330. Contractor shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all Network Providers rendering services on its behalf, in any setting. Contractor shall be accountable for the quality of all Covered Services regardless of the number of contracting layers between Contractor and the Provider. This provision does not create a cause of action against Contractor on behalf of a Medi-Cal beneficiary for malpractice committed by a Subcontractor or a Network Provider.

2. Accountability

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

3. Governing Body

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

- A. Approves the overall QIS and the annual report of the QIS.
- B. Appoints an accountable entity or entities within Contractor's organization to provide oversight of the QIS.
- C. Routinely receives written progress reports from the quality improvement committee describing actions taken, progress in meeting QIS objectives, and improvements made.
- D. Directs the operational QIS to be modified on an ongoing basis, and tracks all review findings for follow-up.

4. Quality Improvement Committee

- A. Contractor shall implement and maintain a Quality Improvement Committee (QIC) designated by, and accountable to, the governing body; the committee shall be facilitated by the medical director or a physician designee. Contractor must ensure that Subcontractors and Network Providers, who are representative of the composition of the Provider Network including but not limited to Network Providers who provide health

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QUALITY IMPROVEMENT SYSTEM**

care services to Seniors and Persons with Disabilities and chronic conditions (such as asthma, diabetes, congestive heart failure), actively participate on the committee or medical sub-committee that reports to the QIC.

- B. The committee shall meet at least quarterly but as frequently as necessary to demonstrate follow-up on all findings and required actions. The activities, findings, recommendations, and actions of the committee shall be reported to the governing body in writing on a scheduled basis.
- C. Contractor shall maintain minutes of committee meetings and minutes shall be submitted to DHCS quarterly. Contractor shall maintain a process to ensure rules of confidentiality are maintained in quality improvement discussions as well as avoidance of conflict of interest on the part of committee members.

5. Provider Participation

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

6. Delegation of Quality Improvement Activities

- A. Contractor is accountable for all quality improvement functions and responsibilities (e.g. Utilization Management, Credentialing and Site Review) that are delegated to Subcontractors. If Contractor delegates quality improvement functions, Contractor and Subcontractor shall include in their Subcontractor Agreement, at a minimum:
 - 1) Quality improvement responsibilities, and specific delegated functions and activities of the Contractor and Subcontractor.
 - 2) Contractor's oversight, monitoring, and evaluation processes and Subcontractor's agreement to such processes.
 - 3) Contractor's reporting requirements and approval processes. The agreement shall include Subcontractor's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly.
 - 4) Contractor's actions/remedies if Subcontractor's obligations are not met.
- B. Contractor shall maintain a system to ensure accountability for delegated quality improvement activities, that at a minimum:

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QUALITY IMPROVEMENT SYSTEM**

- 1) Evaluates Subcontractor's ability to perform the delegated activities including an initial review to assure that the Subcontractor has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities.
- 2) Ensures Subcontractor meets standards set forth by the Contractor and DHCS.
- 3) Includes Contractor's continuous monitoring, evaluation and approval of the delegated functions.

7. Written Description

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

- A. Organizational commitment to the delivery of quality health care services as evidenced by goals and objectives which are approved by Contractor's governing body and periodically evaluated and updated.
- B. Organizational chart showing the key staff and the committees and bodies responsible for quality improvement activities including reporting relationships of QIS committee(s) and staff within Contractor's organization.
- C. Qualifications of staff responsible for quality improvement studies and activities, including education, experience and training.
- D. A process for sharing QIS findings with its Subcontractors and Network Providers.
- E. The role, structure, and function of the quality improvement committee.
- F. The processes and procedures designed to ensure that all Medically Necessary Covered Services are available and accessible to all Members regardless of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, or identification with any other persons or groups defined in Penal Code 422.56, and that all Covered Services are provided in a culturally and linguistically appropriate manner.
- G. A description of the mechanisms used to continuously review, evaluate, and improve access to and availability of services. The description shall include methods to ensure that Members are able to obtain appointments within established standards for time or distance, timely access, and alternative access as defined in APL 21-006, and W&I Code Sections

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QUALITY IMPROVEMENT SYSTEM**

14197 and 14197.04.

- H. Description of the quality of clinical care services provided, including, but not limited to, preventive services for children and adults, perinatal care, primary care, specialty, emergency, inpatient, and ancillary care services.
- I. Description of the activities, including activities used by Members that are Seniors and Persons with Disabilities or persons with chronic conditions, and Members who use MLTSS in accordance with the standards set forth in 42 CFR 438.330(b)(5), designed to assure the provision of case management, coordination and continuity of care services. Such activities shall include, but are not limited to, those designed to assure availability and access to care, clinical services, and care management.

8. Quality Improvement Annual Report

Contractor shall develop an annual quality improvement report for submission to DHCS on an annual basis. Contractor's responsibilities shall include, but are not limited to:

- A. Providing an annual report to DHCS that includes a comprehensive assessment of the quality improvement activities undertaken and an evaluation of areas of success and needed improvements in services rendered within the quality improvement program, including but not limited to, the collection of aggregate data on utilization; the quality review of services rendered; the results of the External Accountability Set measures; and, outcomes/findings from Performance Improvement Projects (PIPs), consumer satisfaction surveys, and collaborative initiatives.
- B. Providing copies of all final reports of independent private accrediting agencies (e.g. JCAHO, NCQA) relevant to Contractor's Medi-Cal line of business, including:
 - 1) Accreditation status, survey type, and level, as applicable;
 - 2) Accreditation agency results, including recommended actions or improvements, corrective action plans, and summaries of findings; and
 - 3) Expiration date of the accreditation.
- C. Providing an annual report to DHCS that includes an assessment of all Subcontractors performance of delegated quality improvement activities.
- D. Upon request from DHCS to Contractor, authorizing any independent private accrediting agency to provide DHCS a copy of its most recent

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QUALITY IMPROVEMENT SYSTEM**

accreditation review.

9. External Quality Review Requirements

At least annually or as designated by DHCS, DHCS shall arrange for an External Quality Review of Contractor by an entity qualified to conduct such reviews in accordance with Title 22 CCR Section 53860(d), Title 42, USC, Section 1396u-2(c)(2), and 42 CFR 438.350, 438.358, and 438.364. Contractor shall cooperate with and assist the External Quality Review Organization (EQRO) contracted with DHCS in the conduct of this review. Contractor shall comply with the following requirements, as well as the activities specified in APL 17-014, including the external quality review protocol issued by CMS which provides detailed instructions on how to complete the activities.

A. External Accountability Set (EAS) Performance Measures

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

B. Under/Over-Utilization Monitoring

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

C. Performance Improvement Projects (PIPs)

- 1) For this Contract, Contractor is required to conduct or participate in PIPs, including any PIP required by CMS, in accordance with 42 CFR 438.330. Contractor shall conduct or participate in, at a minimum, two (2) PIPs per year, as approved by DHCS. If Contractor holds multiple managed care contracts with DHCS, Contractor is required to conduct or participate in two PIPs for each

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contract. At its sole discretion, DHCS may require Contractor to conduct or participate in additional PIPs.

- 2) Contractor shall comply with APL 17-014, as well as any subsequent updates, and shall use the PIP reporting format as designated therein to request approval of proposed PIPs from DHCS and to report at least annually to DHCS on the status of each PIP.

D. Consumer Satisfaction Survey

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

E. Network Adequacy Validation

Contractor is required to participate in the validation of Network adequacy from the preceding 12 months to comply with requirements set forth in 42 CFR 438.68 and 42 CFR 438.14(b)(1).

F. Encounter Data Validation

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

G. Focused Studies

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

H. Technical Assistance

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

10. Site Review

**Exhibit A, Attachment 4
QUALITY IMPROVEMENT SYSTEM**

A. General Requirement

Contractor shall conduct Facility Site and Medical Record reviews on all Primary Care Provider sites in accordance with the Site Reviews APL 20-006 and Title 22 CCR Section 53856. Contractor shall also conduct Facility Site Physical Accessibility reviews on Primary Care Provider sites, and all Provider sites which serve a high volume of SPD beneficiaries, in accordance with the Site Review Policy Letter, PL 12-006 and W&I Code Section 14182(b)(9).

B. Pre-Operational Site Reviews

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

C. Credentialing Site Review

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

D. Corrective Actions

Contractor shall ensure that a corrective action plan is developed to correct cited deficiencies and that corrections are completed and verified within the established guidelines as specified in the Site Reviews APL 22-017. Primary Care Provider sites that do not correct cited differences are to be terminated from Contractor's Network.

E. Data Submission

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

F. Continuing Oversight

Contractor shall retain accountability for all site review activities whether

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carried out by Contractor, completed by other Medi-Cal Managed Care contractors or Subcontractors.

11. Disease Surveillance

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

12. Credentialing and Recredentialing

Contractor shall implement and maintain written policies and procedures concerning the initial credentialing, recredentialing, recertification, and reappointment of Network Providers, developed by the Department in accordance with 42 CFR 438.214 and APL 19-004, and including but not limited to: Primary Care Physicians (PCP); Specialists; Providers for acute, behavioral health, and substance use disorders; and MLTSS Providers as appropriate per the requirements in Exhibit A, Attachment 21, Managed Long Term Services and Supports, Provision 4, Provider Network. Contractor shall ensure those policies and procedures are reviewed and approved by the governing body, or designee. Contractor shall ensure that the responsibility for recommendations regarding credentialing decisions will rest with a credentialing committee or other peer review body.

A. Standards

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

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

B. Delegated Credentialing

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

C. Credentialing Provider Organization Certification

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Contractor and their Subcontractors and Network Providers may obtain credentialing provider organization certification (POC) from the National Committee on Quality Assurance (NCQA). Contractor may accept evidence of NCQA POC certification in lieu of a monitoring visit at delegated physician organizations.

D. Disciplinary Actions

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

E. Medi-Cal and Medicare Provider Status

Contractor will verify that its Subcontractors and Network Providers have not been terminated as Medi-Cal or Medicare Providers or have not been placed on the Suspended and Ineligible Provider List or Restricted Provider Database. As outlined in APL 21-003, Contractor must not maintain contracts with Network Providers or Subcontractors who have been terminated by either Medicare or Medi-Cal, placed on the Suspended and Ineligible Provider List, or placed on a temporary suspension on the Restricted Provider Database.

F. Health Plan Accreditation

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

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

G. Credentialing of Other Non-Physician Medical Practitioners

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

13. Medical Records

A. General Requirement

**Exhibit A, Attachment 4
QUALITY IMPROVEMENT SYSTEM**

Contractor shall ensure that appropriate Medical Records for Members, pursuant to Title 28, CCR, Section 1300.80(b)(4), 42 United States Code (USC) Section 1396a(w), 42 CFR 456.111 and 42 CFR 456.211, shall be available to health care Providers at each Encounter in accordance with Title 28 CCR Section 1300.67.1(c) and Title 22 CCR Section 53861, and APL 20-006.

B. Medical Records

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

- 1) For storage and filing of medical records including: collection, processing, maintenance, storage, retrieval identification, and distribution.
- 2) To ensure that medical records are protected and confidential in accordance with all Federal and State law.
- 3) For the release of information and obtaining consent for treatment.
- 4) To ensure maintenance of medical records in a legible, current, detailed, organized and comprehensive manner (records may be electronic or paper copy).

C. On-Site Medical Records

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

D. Member Medical Record

Contractor shall ensure that a complete medical record is maintained for each Member in accordance with Title 22 CCR Section 53861, that reflects all aspects of patient care, including ancillary services, and at a minimum includes:

- 1) Member identification on each page; personal/biographical data in the record.
- 2) Member's preferred language (if other than English) prominently noted in the record, as well as the request or refusal of language/interpretation services.
- 3) All entries dated and author identified; for Member visits, the entries shall include at a minimum, the subjective complaints, the objective findings, and the plan for diagnosis and treatment.

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- 4) The record shall contain a problem list, a complete record of immunizations and health maintenance or preventive services rendered.
- 5) Allergies and adverse reactions are prominently noted in the record.
- 6) All informed consent documentation, including the human sterilization consent procedures required by Title 22 CCR Sections 51305.1 through 51305.6, if applicable.
- 7) Reports of emergency care provided (directly by the contracted Provider or through an emergency room) and the hospital discharge summaries for all hospital admissions.
- 8) Consultations, referrals, Specialists, pathology, and laboratory reports. Any abnormal results shall have an explicit notation in the record.
- 9) 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.
- 10) Health education behavioral assessment and referrals to health education services.

**Exhibit A, Attachment 5
UTILIZATION MANAGEMENT**

1. Utilization Management Program

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

- A. Qualified staff responsible for the UM program.
- B. The separation of medical decisions from fiscal and administrative management to assure those medical decisions will not be unduly influenced by fiscal and administrative management. Compensation of individuals or entities that conduct UM activities shall not be structured to provide incentives to deny, limit, or discontinue Medically Necessary Covered Services.
- C. Contractor shall ensure that the UM program allows for a second opinion from a qualified health professional at no cost to the Member.
- D. Established criteria for approving, modifying, deferring, or denying requested services. Contractor shall utilize evaluation criteria and standards to approve, modify, defer, or deny services. Contractor shall document the manner in which Network Providers are involved in the development and or adoption of specific criteria used by Contractor.
- E. Contractor shall communicate to health care practitioners the procedures and services that require prior authorization and ensure that all contracting health care practitioners are aware of the procedures and timeframes necessary to obtain prior authorization for these services.
- F. An established specialty referral system to track and monitor referrals requiring Prior Authorization through Contractor. The system shall include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals. This specialty referral system should include non-contracting Providers.

Contractor shall ensure that all Network Providers are aware of the referral processes and tracking procedures.

- G. The integration of UM activities into the Quality Improvement System (QIS), including a process to integrate reports on review of the number and types of Appeals, denials, deferrals, and modifications to the appropriate QIS staff.
- H. Contractor shall ensure its UM program timelines and processes do not impose Quantitative Treatment Limitations (QTL), or Non-Quantitative Treatment Limitations (NQTL) more stringently on covered mental health and substance use disorder services than are imposed on

**Exhibit A, Attachment 5
UTILIZATION MANAGEMENT**

medical/surgical services in accordance with the parity in mental health and substance use disorder requirements in 42 CFR 438.900 et seq., to its timelines and processes.

- I. Contractor shall make its UM or utilization review policies and procedures available to Members and Providers. These policies and procedures shall cover how Contractor, Subcontractors, or Network Providers authorize, modify, delay, or deny health care services via Prior Authorization, concurrent authorization, or retrospective authorization, under the benefits provided by Contractor.
 - 1) Contractor shall ensure that policies and procedures for authorization decisions are based on the Medical Necessity of a requested health care service, and are consistent with criteria or guidelines supported by sound clinical principles.
 - 2) Contractor shall ensure the policies, processes, strategies, evidentiary standards, and other factors used for UM or utilization review are consistently applied to medical/surgical, mental health, and substance use disorder services and benefits.
 - 3) Contractor shall notify Network Providers, as well as Members and Potential Enrollees upon request, of all services that require Prior Authorization, concurrent authorization, or retrospective authorization, and ensure that all Network Providers are aware of the procedures and timeframes necessary to obtain authorization for these services.

These activities shall be done in accordance with Health and Safety Code sections 1363.5 and 1367.01, and 28 CCR sections 1300.70(b)(2)(H) & (c) and 1300.07(a)(3) and (c).

2. Prior Authorizations and Review Procedures

Contractor shall ensure that its Prior Authorization, concurrent review, and retrospective review procedures meet the following minimum requirements:

- A. Consult with the requesting Provider for medical services, when appropriate.
- B. Decisions to deny or to authorize an amount, duration, or scope that is less than requested shall be made by a qualified health care professional with appropriate clinical expertise in treating the medical or behavioral health condition and disease or MLTSS needs. Appropriate clinical expertise may be demonstrated by appropriate specialty training, experience or certification by the American Board of Medical Specialties. Qualified health care professionals do not have to be an expert in all

**Exhibit A, Attachment 5
UTILIZATION MANAGEMENT**

conditions and may use other resources to make appropriate decisions.

- C. Qualified health care professionals must supervise the review of medical decisions, including service reductions, and a qualified Physician will review all denials that are made, whole or in part, on the basis of Medical Necessity. For purposes of this Provision, a qualified Physician or Contractor's pharmacist may approve, defer, modify, or deny Prior Authorization for pharmaceutical services, provided that such determinations are made under the auspices of and pursuant to criteria established by Contractor's medical director, in collaboration with Contractor's Pharmacy and Therapeutics Committee (PTC) or its equivalent. Contractor must conduct Prior Authorization for pharmaceutical services in accordance with APL 22-012, and as follows:
- 1) Contractor is not responsible for the review of Prior Authorizations provided by an outpatient pharmacy for the following:
 - a) Physician administered drugs;
 - b) Medical supplies;
 - c) Enteral nutritional products; and
 - d) Covered outpatient prescription drugs
 - 2) Contractor must review Prior Authorizations for Physician administered drugs which include prescription drugs administered by a health care professional in a clinic, physician's office, or outpatient setting; medical supplies; and enteral nutritional products. These prescription drugs and supplies are covered under the medical benefit and would be included in the medical claim or encounter.
- D. There is a set of written criteria or guidelines for utilization review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated.
- E. Reasons for decisions are clearly documented.
- F. Notification to Members regarding denied, deferred or modified referrals is made as specified in Exhibit A, Attachment 13, Member Services, Provision 8, Denial, Deferral, or Modification of Prior Authorization Requests. There shall be a well-publicized Appeals procedure for both Providers and patients.
- G. Decisions and Appeals are made in a timely manner and are not unduly delayed for medical conditions requiring time sensitive services.

**Exhibit A, Attachment 5
UTILIZATION MANAGEMENT**

- H. Prior Authorization requirements shall not be applied to emergency services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing.
- I. Records, including any Notice of Action (NOA), shall meet the retention requirements described in Exhibit E, Attachment 2, Provision 19, Audit.
- J. Contractor must notify the requesting Provider of any decision to deny, approve, modify, or delay a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the Provider may be orally or in writing.
- K. All of Contractor's authorization requirements shall comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

3. Timeframes for Medical Authorization

- A. Emergency Care: No Prior Authorization required, following the reasonable person standard to determine that the presenting complaint might be an emergency.
- B. Post-stabilization: Response to request within 30 minutes or the service is deemed approved in accordance with 22 CCR section 53855 (a).
- C. Non-urgent care following an exam in the emergency room: Response to request within 30 minutes or deemed approved.
- D. Concurrent review of authorization for treatment regimen already in place: Within five (5) Working Days or less, consistent with urgency of the Member's medical condition and in accordance with Health and Safety Code section 1367.01(h)(3).
- E. Retrospective review: Within 30 calendar days in accordance with Health and Safety Code section 1367.01(h)(1).
- F. Routine authorizations: As expeditiously as the Member's condition requires but within five (5) Working Days from receipt of the information reasonably necessary to render a decision (these are requests for specialty service, cost control purposes, out-of-Network not otherwise exempt from Prior Authorization) in accordance with Health and Safety Code section 1367.01, but, no longer than 14 calendar days from the receipt of the request. The decision may be deferred and the time limit extended an additional 14 calendar days only where the Member or the Member's Provider requests an extension, or Contractor can provide justification upon request by the State for the need for additional information and how it is in the Member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately

**Exhibit A, Attachment 5
UTILIZATION MANAGEMENT**

processed as such.

- G. Expedited authorizations: Contractor must make expedited authorization decisions for service requests where a Member's Provider indicates, or Contractor, Subcontractor, or Network Provider determines that, following the standard timeframe for Prior Authorizations could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, Contractor must make an expedited authorization decision and provide notice as expeditiously as the Member's health condition requires and not later than 72-hours after receipt of the request for services in accordance with 42 CFR section 438.210(d). Contractor may extend the 72-hour time period by up to 14 calendar days if the Member requests an extension, or if Contractor justifies, to the satisfaction of DHCS upon request, a need for additional information and how the extension is in the Member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.
- H. Hospice Inpatient Care: 24-hour response.
- I. Therapeutic Enteral Formula for Medical Conditions in Infants and Children: Timeframes for medical authorization of Medically Necessary therapeutic enteral formulas for infants and children and the equipment/and supplies necessary for delivery of these special foods are set forth in PL 14-003, W&I Code section 14103.6, and Health and Safety Code section 1367.01.

4. Review of Utilization Data

Contractor shall include within the UM program mechanisms to detect both under- and over-utilization of health care services. Contractor's internal reporting mechanisms used to detect Member utilization patterns shall be reported to DHCS no later than 30 calendar days after the beginning of each calendar year and upon request.

5. Delegating UM Activities

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

**Exhibit A, Attachment 6
PROVIDER NETWORK**

1. Network Capacity

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

2. Network Composition

Contractor shall ensure and monitor an appropriate Provider Network within its Service Area in compliance with W&I Code section 14197, and if necessary to ensure compliance with Network adequacy requirements in this Contract, attempt to contract with Providers in adjoining counties outside of Contractor's Service Area. Contractor's Network must include, but not be limited to, adult and pediatric PCPs, OB/GYN, adult and pediatric behavioral health Providers, adult and pediatric Specialists, Allied Health Personnel, supportive paramedical personnel, hospitals, and an adequate number of accessible inpatient facilities and service sites. In addition, Contractor shall ensure and monitor MLTSS Providers, American Indian Health Service Programs, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Freestanding Birthing Centers (FBCs), where available. Contractor shall submit assurances to DHCS regarding its Network composition in accordance with 42 CFR section 438.207.

3. Provider to Member Ratios

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

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

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

4. Physician Supervisor to Non-Physician Medical Practitioner Ratios

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

- | | | |
|----|---------------------|-----|
| A. | Nurse Practitioners | 1:4 |
|----|---------------------|-----|

**Exhibit A, Attachment 6
PROVIDER NETWORK**

- B. Physician Assistants 1:4
- C. Four (4) Non-Physician Medical Practitioners in any combination that does not include more than three (3) Certified Nurse Midwives or two (2) Physician Assistants.

5. Emergency Services

Contractor shall have, as a minimum, a designated emergency service facility, providing care on a 24 hours a day, 7 day a week basis. This designated emergency service facility will have one or more physicians and one nurse on duty in the facility at all times.

6. Specialists

Contractor shall maintain an adequate Network that includes adult and pediatric Specialists, and at a minimum, core Specialists as described in W&I Code, section 14197(h)(2), within their Network to accommodate the need for specialty care in accordance with 22 CCR section 53853(a), and W&I Code, section 14182(c)(2).

7. Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), and Freestanding Birth Center (FBC) Services

Contractor shall meet federal requirements for access to FQHC, RHC, and FBC services as a mandatory service and benefit, including those in 42 USC Section 1396 b(m). Contractor must include at least one (1) FQHC, one (1) RHC, and one (1) FBC in the Provider Network within Contractor's Service Area, to the extent that the FQHC, RHC and FBC Providers are licensed and recognized under State law and they are available within Contractor's Service Area. Contractor shall reimburse FQHCs, RHCs, and FBCs in accordance with Exhibit A, Attachment 8, Provider Compensation Arrangements, Provision 7. If FQHC, RHC, or FBC services are not available in the Provider Network, Contractor shall reimburse FQHCs, RHCs, and FBCs for services provided out-of-Network to Contractor's Members at a rate determined by DHCS. If FQHC, RHC, or FBC services are not available in Contractor's Provider Network, but are available within DHCS' time or distance standards for access to Primary Care for Contractor's Members in the Service Area, Contractor shall not be obligated to reimburse FQHCs, RHCs, or FBCs for services provided out-of-Network to Members, unless authorized by Contractor.

8. Time or Distance Standard

- A. Contractor shall meet time or distance standards for adult and pediatric PCPs, adult and pediatric core Specialists, OB/GYN primary and specialty care, adult and pediatric outpatient mental health Providers, and hospitals based on county population density and as required by W&I Code section 14197. For MLTSS, Skilled Nursing Facilities (SNFs) and Intermediate

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Care Facilities (ICFs), Contractor shall adhere to availability standards in accordance with W&I Code section 14197.

- B. Contractor must either exhaust all other reasonable options for contracting with Providers, including Providers in adjoining counties outside of Contractor's Service Area, or demonstrate to DHCS that its delivery structure is capable of delivering the appropriate level of care and access as required by W&I Code Section 14197 prior to submitting an Alternate Access Standard (AAS) request to DHCS to meet time or distance standards.
- C. If Contractor is unable to comply with the time or distance standards set forth in W&I Code Section 14197, Contractor must submit an AAS request to DHCS for review and approval in accordance with APL 21-006 detailing how it intends to arrange for Covered Services in accordance with W&I Code Section 14197(e)(3).
- D. If Contractor has received an AAS approval for a core Specialist from DHCS, upon a Member's request Contractor shall assist the Member in obtaining an appointment with the appropriate core Specialist in accordance with W&I Code Section 14197.04. Contractor must either make its best effort to establish a Member-specific case agreement with an Out-of-Network Provider or arrange for an appointment with a Network Provider in the next closest county within the time or distance standards in accordance with W&I Code Section 14197.04. Contractor shall demonstrate how it will arrange for Covered Services to Members through the use of NEMT, NMT, and Telehealth if Contractor does not meet time or distance standards for adult and pediatric PCPs, core Specialists, and outpatient mental health Providers, in accordance with W&I Code Section 14197(f)(2). Contractor shall not be held liable for fulfilling these requirements if either there is no core Specialist within the time or distance standards of this Contract, or the core Specialist has refused such efforts within the previous 12 months.

9. Plan Physician Availability

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

10. Network Provider Availability

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

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beneficiaries.

11. Provider Network Reports

Contractor shall submit to DHCS, in a format specified by DHCS, a report summarizing changes in the Provider Network.

- A. The report shall be submitted at a minimum:
 - 1) Quarterly
 - 2) At the time of a Significant Change, as defined in this Contract and set forth in 42 CFR 438.207 and APL 21-006, to the Network affecting Provider capacity and services, including:
 - a) Change in services or benefits;
 - b) Geographic service area or payments; or
 - c) The composition of, or the payments to, it's Network; or
 - d) Enrollment of a new population.
- B. The report shall identify the following for each termination resulting in a network impact:
 - 1) Geographic access maps for the Members;
 - 2) The percentage of Traditional and Safety-Net Providers;
 - 3) The number of Members assigned to each provider type or facility;
 - 4) The percentage of Members assigned to Traditional and Safety-Net Providers; and
 - 5) The Network Providers who are not accepting new patients.
- C. Contractor shall submit the report 30 calendar days following the end of the reporting quarter.
- D. Contractor shall participate annually in the submission to DHCS of its Provider Network composition report to demonstrate its capacity to serve the current and expected membership in its Service Area in accordance with State standards for access and timeliness of care, 42 CFR 438.207(b), and APL 21-006.
 - 1) Contractor shall demonstrate how it will arrange for Covered Services to Members through the use of NEMT, NMT, and Telehealth if Contractor does not meet time or distance standards

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for adult and pediatric PCPs, core Specialist and outpatient mental health Providers in accordance with W&I Section 14197(f)(2).

12. Subcontractor Reports

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

13. Ethnic and Cultural Composition

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

14. Network Provider Agreements and Subcontractor Agreements

Contractor may enter into Network Provider Agreements and Subcontractor Agreements with other entities in order to fulfill the obligations of the Contract. Contractor shall maintain policies and procedures, approved by DHCS, to ensure that Network Providers and Subcontractors fully comply with all terms and conditions of this Contract. Contractor shall evaluate the prospective Network Providers and Subcontractor's ability to perform the contracted services, shall oversee and remain responsible and accountable for any functions and responsibilities delegated and shall meet the contracting requirements as stated in 42 CFR 438.230(b)(1), (c)(1)(i)-(iv), (c)(2), (c)(3), Title 22 CCR Section 53867, APL 17-004 and this Contract.

A. Laws and Regulations

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

B. Network Provider Agreement Requirements

Network Provider Agreements must contain the following provisions:

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- 1) Specification of the Covered Services to be ordered, referred, or rendered;
- 2) Specification of the term of the agreement, including the beginning and ending dates as well as methods of extension, renegotiation, phaseout, and termination;
- 3) Full disclosure of the method and amount of compensation or other consideration to be received by Network Provider;
- 4) Specification that the agreement shall be governed by and construed in accordance with all applicable laws and regulations governing this Contract, including but not limited to, Knox-Keene Health Care Services Plan Act of 1975, Health and Safety Code Section 1340 *et seq.* (unless expressly excluded under this Contract); Title 28 CCR Section 1300.43 *et seq.*; W&I Code Sections 14000 and 14200 *et seq.*; and Title 22 CCR Sections 53800 *et seq.*;
- 5) Network Providers will comply with all applicable requirements of the DHCS Medi-Cal Managed Care Program, including but not limited to, all applicable federal and State Medicaid and Medi-Cal laws, regulations, sub-regulatory guidance, APLs, and provisions of this Contract;
- 6) Network Providers will submit to Contractor, either directly or through a Subcontractor as applicable, complete, accurate, and timely Encounter Data and Provider Data, and any other reports or data as needed by Contractor, in order for Contractor to meet its data reporting requirements to DHCS;
- 7) Network Providers will maintain and make available to DHCS, upon request, copies of all contracts it enters into related to ordering, referring, or rendering Covered Services under the Network Provider Agreement, and will ensure that all such contracts are in writing;
- 8) Network Providers will make all of its premises, facilities, equipment, books, records, contracts, and computer and other electronic systems pertaining to the Covered Services ordered, referred, or rendered under the terms of the Network Provider Agreement, available for the purpose of an audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in Exhibit E, Attachment 2, Provision 19, Audit and Exhibit E, Attachment 2, Provision 20, Inspection Rights:

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- a) In accordance with inspections and audits, as directed by DHCS, CMS, DHHS Inspector General, the Comptroller General, Department of Justice (DOJ), DMHC, or their designees; and
 - b) At all reasonable times at a Network Provider's place of business or at such other mutually agreeable location in California.
- 9) Network Providers will maintain all of its books and records, including Encounter Data, in accordance with good business practices and generally accepted accounting principles for a term of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later;
- 10) Network Providers will timely gather, preserve and provide to DHCS, CMS, Attorney General's Division of Medi-Cal Fraud and Elder Abuse (DMFEA), and any authorized State or federal regulatory agencies, any records in Network Provider's possession, in accordance with Exhibit E, Attachment 2, Provision 25, Records Related to Recovery for Litigation;
- 11) Network Providers will assist Contractor, or if applicable a Subcontractor, in the transfer of a Member's care in accordance with Exhibit E, Attachment 2, Provision 15, Phaseout Requirements, in the event of Contract termination, or in the event of termination of the Network Provider for any reason;
- 12) Specification that the Network Provider Agreement will be terminated, or subject to other remedies, if DHCS or Contractor determine that the Network Provider has not performed satisfactorily;
- 13) Network Providers will hold harmless both the State and Members in the event Contractor or, if applicable a Subcontractor, cannot or will not pay for Covered Services ordered, referred, or rendered by Network Provider pursuant to the Network Provider Agreement;
- 14) Network Providers will not bill Members for Medi-Cal Covered Services;
- 15) Contractor must inform Network Providers of prospective requirements added by State or federal law or DHCS related to this Contract that impact obligations undertaken through the Network Provider Agreement before the requirement would be effective, and agreement by Network Providers to comply with the new

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requirements within 30 calendar days of the effective date, unless otherwise instructed by DHCS;

- 16) Network Providers to ensure that cultural competency, sensitivity, health equity, and diversity training is provided for employees and staff at key points of contact with Members;
- 17) Network Providers to provide interpreter services for Members and comply with language assistance standards developed pursuant to Health and Safety Code Section 1367.04;
- 18) Network Providers must notify Contractor, and Contractor's Subcontractor, within ten (10) Working Days of any suspected Fraud, Waste, or Abuse and a provision that allows Contractor to share such information with DHCS in accordance with Exhibit E, Attachment 2, Provision 26, Fraud and Abuse Reporting;
- 19) Network Providers must:
 - a) Report to Contractor or Contractor's Subcontractor when it has received an Overpayment;
 - b) Return the Overpayment to Contractor or Contractor's Subcontractor within 60 calendar days of the date the Overpayment was identified; and
 - c) Notify Contractor or Contractor's Subcontractor in writing, the reason for the Overpayment in accordance with Exhibit E, Attachment 2, Provision 34, Treatment of Recoveries, and 42 CFR Section 438.608(d)(2); and
- 20) Confirmation of a Network Provider's right to all protections afforded them under the Health Care Providers' Bill of Rights, including, but not limited to a Network Provider's right to access Contractor's dispute resolution mechanism and submit a grievance pursuant to Health and Safety Code Section 1367(h)(1).

C. Subcontractor Agreement Requirements

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

- 1) Specification of Contractor's obligations and functions undertaken by the Subcontractor;

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- 2) Specification of the term of the agreement, including the beginning and ending dates as well as methods of extension, renegotiation, phaseout, and termination;
- 3) Full disclosure of the method and amount of compensation or other consideration to be received by Subcontractor;
- 4) Specification that the Subcontractor Agreement and amendments thereto shall become effective only as set forth in Exhibit A, Attachment 6;
- 5) Subcontractor's assignment or delegation of the Subcontractor Agreement is void unless prior written approval is obtained from DHCS;
- 6) Specification that the Subcontractor Agreement shall be governed by and construed in accordance with all applicable laws and regulations governing this Contract, including but not limited to 42 CFR Section 438.230; Knox-Keene Health Care Services Plan Act of 1975, Health and Safety Code Section 1340 *et seq.* (unless otherwise expressly excluded under this Contract); Title 28 CCR Section 1300.43 *et seq.*; W&I Code Section 14000 *et seq.*; and Title 22 CCR Section 53800 *et seq.*;
- 7) Subcontractor must comply with all applicable requirements of the DHCS Medi-Cal Managed Care Program, pertaining to the obligations and functions undertaken pursuant to the Subcontractor Agreement, including but not limited to, all applicable Medicaid and Medi-Cal laws, regulations, sub-regulatory guidance, APLs, and the provisions of this Contract;
- 8) Language comparable to Exhibit A, Attachment 8, Provision 13, Contracting and Non-Contracting Emergency Providers & Post-Stabilization, for those Subcontractors obligated to reimburse Providers of Emergency Services;
- 9) Subcontractor will submit to Contractor, either directly or through a Subcontractor as applicable, complete, accurate, and timely Encounter Data and Provider Data, and any other reports and data as needed by Contractor, in order for Contractor to meet its reporting requirements to DHCS;
- 10) Subcontractor will comply with all monitoring provisions of this Contract and any monitoring requests by DHCS;
- 11) Subcontractor will maintain and make available to DHCS, upon request, copies of all contracts it enters into related to the

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performance of the obligations and functions it undertakes pursuant to the Subcontractor Agreement, and to ensure that such contracts are in writing;

- 12) Subcontractor must make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the obligations and functions undertaken pursuant to the Subcontractor Agreement, available for the purpose of an audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in Exhibit E, Attachment 2, Provision 19, Audit, and Exhibit E, Attachment 2, Provision 20, Inspection Rights:
 - a) In accordance with inspections and audits, as directed by DHCS, CMS, DHHS Inspector General, the Comptroller General, DOJ, DMHC, or their designees; and
 - b) At all reasonable times at Subcontractor's place of business or at such other mutually agreeable location in California.
- 13) Subcontractor will maintain all of its books and records, including Encounter data, in accordance with good business practices and generally accepted accounting principles for a term of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later;
- 14) Subcontractor will timely gather, preserve, and provide to DHCS, CMS, DMFEA, and any authorized State or federal regulatory agencies, any records in Subcontractor's possession, in accordance with Exhibit E, Attachment 2, Provision 25, Records Related to Recovery for Litigation;
- 15) Subcontractor will assist Contractor in the transfer of a Member's care as needed, and in accordance with Exhibit E, Attachment 2, Provision 15, Phaseout Requirements, in the event of Contract termination for any reason;
- 16) Subcontractor will notify DHCS in the event the Subcontractor Agreement is amended or terminated for any reason;
- 17) Subcontractor will hold harmless both the State and Members in the event Contractor, or another Subcontractor as applicable, cannot or will not pay for the obligations and functions undertaken pursuant to the Subcontractor Agreement;
- 18) Subcontractor will participate and cooperate in Contractor's Quality Improvement System;

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- 19) If Subcontractor takes on Quality Improvement activities, the Subcontractor Agreement shall include those provisions stipulated in Exhibit A, Attachment 4, Provision 6, Delegation of Quality Improvement Activities;
- 20) To the extent Subcontractor undertakes coordination of care obligations and functions for Members, an agreement to share with Subcontractor any utilization data that DHCS has provided to Contractor, and agreement by the Subcontractor's to receive the utilization data provided and use it solely for the purpose of Member Care Coordination;
- 21) Contractor will inform Subcontractor of prospective requirements added by federal or State law or DHCS related to this Contract that impact obligations and functions undertaken pursuant to the Subcontractor Agreement before the requirement is effective, and Subcontractor's agreement to comply with the new requirements within 30 calendar days of the effective date, unless otherwise instructed by DHCS;
- 22) Subcontractor will ensure that cultural competency, sensitivity, health equity, and diversity training is provided for Subcontractor's staff at key points of contact with Members;
- 23) Subcontractor, to the extent Subcontractor communicates with Members, will provide interpreter services for Members, and to comply with language assistance standards developed pursuant to Health and Safety Code Section 1367.04;
- 24) Subcontractor will notify Contractor within ten (10) Working Days of any suspected Fraud, Waste, or Abuse and a provision that allows Contractor to share such information with DHCS in accordance with Exhibit E, Attachment 2, Provision 26, Fraud and Abuse Reporting;
- 25) Subcontractor will:
 - a) Report to Contractor when it has received an Overpayment;
 - b) Return the Overpayment to Contractor within 60 calendar days after the date the Overpayment was identified; and
 - c) Notify Contractor in writing, the reason for the Overpayment (42 CFR Section 438.608(d)(2));
- 26) Subcontractor will perform the obligations and functions of Contractor undertaken pursuant to the Subcontractor Agreement,

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including but not limited to reporting responsibilities, in compliance with Contractor's obligations under this Contract in accordance with 42 CFR Section 438.230(c)(1)(ii); and

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

D. Departmental Approval - Non-Federally Qualified HMOs

- 1) Except as provided in Exhibit A, Attachment 8, Provider Compensation Arrangements, Provision 7 regarding Federally Qualified Health Centers and Rural Health Clinics, Subcontractor Agreement entered into by Contractor which is not a federally qualified HMO shall become effective upon approval by DHCS in writing, or by operation of law where DHCS has acknowledged receipt of the proposed Subcontractor Agreement, and has failed to approve or disapprove the proposed Subcontractor Agreement within 60 calendar days of receipt. Within five (5) Working Days of receipt, DHCS shall acknowledge in writing the receipt of any material sent to DHCS by Contractor for approval.
- 2) Subcontractor Agreement amendments shall be submitted to DHCS for prior approval at least 30 calendar days before the effective date of any proposed changes governing compensation, services, or term. Proposed changes which are neither approved or disapproved by DHCS, shall become effective by operation of law 30 calendar days after DHCS has acknowledged receipt or upon the date specified in the Subcontractor Agreement amendment, whichever is later.

E. Departmental Approval - Federally Qualified HMOs

Except as provided in Exhibit A, Attachment 8, Provider Compensation Arrangements, Provision 7 regarding Federally Qualified Health Centers and Rural Health Clinics, Subcontractor Agreements entered into by Contractor which is a federally qualified HMO shall be:

- 1) Exempt from prior approval by DHCS.
- 2) Submitted to DHCS upon request.

E. Public Records

Network Provider Agreements and Subcontractor Agreements entered into by Contractor and all information received in accordance with the

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Network Provider Agreements and Subcontractor Agreements, to the extent such agreements are received by DHCS, will be public records on file with DHCS, except as specifically exempted in statute. DHCS shall ensure the confidentiality of information and contractual provisions filed with DHCS which are specifically exempted by statute from disclosure, in accordance with the statutes providing the exemption. The names of the officers and owners of the Subcontractor, stockholders owning more than five (5) percent of the stock issued by the Subcontractor and major creditors holding more than five (5) percent of the debt of the Subcontractor will be attached to the Subcontractor Agreement at the time the Subcontractor Agreement is presented to DHCS.

15. Network Provider Agreements and Subcontractor Agreements with Federally Qualified Health Centers and Rural Health Clinics (FQHC/RHC)

Network Provider Agreements and Subcontractor Agreements with FQHCs shall also meet the requirements of Provision 14 above and reimbursement requirements in Exhibit A, Attachment 8, Provision 7. In Network Provider Agreements and Subcontractor Agreements with FQHCs and RHCs where a negotiated reimbursement rate is agreed to as total payment, a provision that such rate constitutes total payment shall be included in the Network Provider Agreements and Subcontractor Agreements.

16. Traditional and Safety-Net Providers Participation

Contractor shall establish participation standards pursuant to Title 22 CCR Section 53800(b)(2)(C)(1) to ensure participation and broad representation of Traditional and Safety-Net Providers within a Service Area. Contractor shall maintain the percentage of Traditional and Safety-Net Provider within a Service Area submitted and approved by DHCS. Federally Qualified Health Centers meet the definitions of both Traditional and Safety-Net Providers.

17. Network Provider Agreements Safety-Net Providers

Contractor shall offer a Network Provider Agreement to any Safety-Net Provider that agrees to provide its scope of services in accord with the same terms and conditions that Contractor requires of other similar Providers.

18. Termination of Safety-Net Provider Network Provider Agreement

Contractor shall notify DHCS of intent to terminate a Network Provider Agreement with a Safety-Net Provider at least 30 calendar days prior to the effective date of termination unless such Provider's license has been revoked or suspended or where the health and welfare of a Member is threatened, in which event termination shall be effective immediately, without DHCS prior approval, and Contractor shall notify DHCS concurrently with the termination.

19. Nondiscrimination in Provider Contracts

**Exhibit A, Attachment 6
PROVIDER NETWORK**

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

20. Provider Screening and Enrollment

All Network Providers must be screened and enrolled in accordance with Title 42 CFR 438.602(b), and APL 19-004.

- A. DHCS, and other designated State departments, are required to enroll Network Providers in accordance with 42 CFR Section 438.602(b), APL 19-004. DHCS has provided Contractor with the option to enroll Network Providers under delegated authority in accordance with APL 19-004.
- B. If Contractor elects to enroll Network Providers under its delegated authority, Contractor must screen and enroll Provider types for which there is an existing Medi-Cal Fee-For-Service state-level pathway. Contractor must also screen and enroll Provider types that are not currently enrolled in Medi-Cal FFS if those Provider types are necessary to maintain an adequate Network. Contractor shall confirm that a Provider is enrolled, or not subject to enrollment, prior to contracting with the Provider.

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

**Exhibit A, Attachment 7
PROVIDER RELATIONS**

1. Exclusivity

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

2. Provider Grievance

Contractor shall have a formal procedure to accept, acknowledge, and resolve Provider Grievances. A Provider of medical services may submit to Contractor a Grievance concerning the authorization or denial of a service; denial, deferral or modification of a Prior Authorization request on behalf of a Member; or the processing of a payment or non-payment of a claim by Contractor. This process shall be communicated to Network Providers and non-contracting Providers.

3. Non-Contracting, Non-Emergency Provider Communication

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

4. Contractor's Provider Manual

Contractor shall issue a provider manual to Network Provider that includes information and updates regarding Medi-Cal services, policies and procedures, statutes, regulations, telephone access, special requirements, and the Member Grievance, Appeal, and State Hearing process. Contractor's Provider Manual shall include the following Member rights information:

- A. Member's right to a State Hearing, how to obtain a State Hearing, and representation rules at a State Hearing;
- B. Member's right to file Grievances and Appeals and their requirements and timeframes for filing;
- C. Availability of assistance in filing;
- D. Toll-free numbers to file oral Grievances and Appeals; and
- E. Member's right to request continuation of benefits during an Appeal or State Hearing.

5. Network Provider Training

- A. Contractor shall ensure that all Network Providers receive training regarding the Medi-Cal Managed Care program in order to operate in full compliance with the Contract and all applicable federal and State statutes and regulations. Contractor shall ensure that Network Provider training

**Exhibit A, Attachment 7
PROVIDER RELATIONS**

relates to Medi-Cal Managed Care services, policies, procedures and any modifications to existing services, policies or procedures. Training shall include methods for sharing information between Contractor, Network Provider, Member and/or other healthcare professionals, which includes ensuring accurate contact information. Training must also include maintaining operational standards for ensuring telephone access for Members during hours of operation. Contractor shall conduct training for all Network Providers within ten (10) working days after Contractor places a newly contracted Network Provider on active status. Contractor shall ensure that Network Provider training includes information on all Member rights specified in Exhibit A, Attachment 13, Member Services, including the right to full disclosure of health care information, the right to actively participate in health care decisions and the Member's right to timely access to care. Contractor shall ensure that ongoing training is conducted when deemed necessary by either Contractor or the State.

- B. Contractor shall develop and implement a process to provide information to Network Providers and to train providers on a continuing basis regarding clinical protocols, evidenced-based practice guidelines and DHCS-developed cultural awareness and sensitivity instruction for Seniors and Persons with Disabilities or chronic conditions. This process shall include an educational program for Network Providers regarding health needs specific to this population that utilizes a variety of educational strategies, including but not limited to, posting information on websites as well as other methods of educational outreach to Network Providers.
- C. For Out-of-Network Providers who will not receive Network Provider training, Contractor shall develop and implement a process to provide them with Contractor's clinical protocols and evidence-based practice guidelines. Contractor shall arrange to provide these protocols and guidelines at the time that Contractor enters into an agreement with an Out-of-Network Provider.
- D. In compliance with 42 CFR section 438.236(b), Contractor shall ensure that practice guidelines are based on valid and reliable clinical evidence or a consensus of Providers in that particular field, consider the needs of Contractor's Members, are adopted in consultation with Network Providers, and are reviewed and updated periodically as appropriate. In addition to Network Provider training, Contractor shall disseminate their practice guidelines to all affected Providers.

6. Submittal of Inpatient Days Information

Upon DHCS' written request, Contractor shall report hospital inpatient days to DHCS as required by Welfare and Institutions Code, Section 14105.985(b)(2) for the time period and in the form and manner specified in DHCS' request, within 30

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calendar days of receipt of the request. Contractor shall submit additional reports to DHCS, as requested, for the administration of the Disproportionate Share Hospital program.

7. Emergency Department Protocols

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

- A. Description of telephone access to triage and advice systems used by the Contractor.
- B. Contractor's contact person responsible for coordinating services and who can be contacted 24 hours a day.
- C. Written referral procedures (including after-hours instruction) that emergency department personnel can provide to Medi-Cal Members who present at the emergency department for non-emergency services.
- D. Procedures for emergency departments to report system and/or protocol failures and process for ensuring corrective action.

8. Prohibited Punitive Action Against the Provider

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

**Exhibit A, Attachment 8
PROVIDER COMPENSATION ARRANGEMENTS**

1. Compensation

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

2. Capitation Payments

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

3. Physician Incentive Plan Requirements

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

- A. No specific payment is made directly or indirectly under the incentive plan to a physician or physician group as an inducement to reduce or limit Medically Necessary Covered Services provided to an individual Member; and
- B. The stop-loss protection (reinsurance), beneficiary survey, and disclosure requirements of 42 CFR 417.479, 42 CFR 422.208 and 42 CFR 422.210 are met by Contractor.

4. Identification of Responsible Payor

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

5. Claims Processing

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

- A. Contractor shall comply with Section 1932(f), Title XIX, Social Security Act (42 U.S.C. Section 1396u-2(f), and Health and Safety Code Sections 1371 through 1371.36. Contractor shall be subject to any remedies, including interest payments provided for in these sections, if it fails to meet the standards specified in these sections.
- B. Contractor shall pay 90% of all clean claims from practitioners who are in individual or group practices or who practice in shared health facilities, including American Indian Health Service Program Providers, within 30 days of the date of receipt and 99% of all clean claims within 90 days. The date of receipt shall be the date Contractor receives the claim, as indicated by its date stamp on the claim. The date of payment shall be the date of the check or other form of payment.
- C. Contractor shall maintain procedures for prepayment and post payment claims review, including review of data related to Network Provider, Member and Covered Services for which payment is claimed.
- D. Contractor shall maintain sufficient claims processing/tracking/payment systems capability to: comply with applicable State and federal law, regulations and Contract requirements, determine the status of received claims, and calculate the estimate for incurred and unreported claims, as specified by Title 28, CCR, Sections 1300.77.1 and 1300.77.2.
- E. Contractor shall submit claims payment summary reports to DHCS on a quarterly basis as specified in Exhibit A, Attachment 2, Provision 2, Paragraph B.3).

6. Prohibited Claims

- A. Except in specified circumstances, Contractor and any of its Affiliates and Subcontractors shall not submit a claim or demand, or otherwise collect reimbursement for any services provided under this Contract to a Medi-Cal Member. Collection of claim may be made under those circumstances described in Title 22 CCR Sections 53866, 53220, and 53222.
- B. Contractor shall not hold Members liable for Contractor's debt if Contractor becomes insolvent. In the event Contractor becomes insolvent, Contractor shall cover continuation of services to Members for the duration of the period for which payment has been made, as well as for inpatient admissions up until discharge.

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

A. FQHCs Availability and Reimbursement Requirement

If FQHC services are not available in the Provider Network of any Medi-Cal Managed Care Health Plan in the county, Contractor shall reimburse non-contracting FQHCs for services provided to Contractor's Members at a level and amount of payment that is not less than Contractor makes for the same scope of services furnished by a Provider that is not a FQHC or RHC. If FQHC services are not available in Contractor's Provider Network, but are available within DHCS' time or distance standards for access to Primary Care for Contractor's Members within the Provider Network in the county, Contractor shall not be obligated to reimburse non-contracting FQHCs for services provided to Contractor's Members (unless authorized by Contractor).

B. Required Terms and Conditions for Network Provider Agreements with Federally Qualified Health Centers/Rural Health Clinics (FQHC/RHC)

Contractor shall submit to DHCS, within 30 calendar days of a request and in the form and manner specified by DHCS, the services provided and the reimbursement level and amount for each of Contractor's FQHC and RHC Network Provider Agreements. Contractor shall certify in writing to DHCS within 30 calendar days of DHCS' written request that, pursuant to Welfare and Institutions Code Section 14087.325(b) and (d), as amended by Chapter 894, Statutes of 1998, FQHC and RHC Network Provider Agreement terms and conditions are the same as offered to other Network Providers providing a similar scope of service and that reimbursement is not less than the level and amount of payment that Contractor makes for the same scope of services furnished by a Provider that is not a FQHC or RHC. Contractor is not required to pay FQHCs and RHCs the Medi-Cal per visit rate for that facility. At its discretion, DHCS reserves the right to review and audit Contractor's FQHC and RHC reimbursement to ensure compliance with State and federal law and shall approve all FQHC and RHC Network Provider Agreements consistent with the provisions of Welfare and Institutions Code, Section 14087.325(h).

To the extent that American Indian Health Service Programs qualify as FQHCs or RHCs, the above reimbursement requirements shall apply to Network Provider Agreements with American Indian Health Service Programs. Contractor must also pay an amount equal to what Contractor would pay a subcontracted FQHC or RHC and DHCS must pay any supplemental payment, pursuant to 42 CFR 438.14(c), to an American Indian Health Service Program that qualifies as a FQHC or RHC but is not a Network Provider.

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- C. American Indian Health Service Program Providers
- 1) Contractor shall attempt to contract with each American Indian Health Service Program as set forth in Title 22 CCR Sections 55120-55180. Contractor shall reimburse American Indian Health Service Programs at the applicable Fee-For-Service Medi-Cal rate for services provided prior to January 1, 2018 to Members who are qualified to receive services from an American Indian Health Service Program as set forth in 42 USC Section 1396u-2(h)(2), and Section 5006 of Title V of the American Recovery and Reinvestment Act of 2009. Contractor shall reimburse an American Indian Health Service Program that qualifies as a FQHC but is not a Network Provider as set forth in 42 CFR 438.14(c)(1).
 - 2) For services provided on or after January 1, 2018 to Members who are qualified to receive services from an American Indian Health Service Program as set forth under Supplement 6, Attachment 4.19-B, of the California Medicaid State Plan, regardless of whether the American Indian Health Service Program is a Network Provider:
 - a) Contractor shall reimburse American Indian Health Service Programs at the most current and applicable outpatient per-visit rate published in the Federal Register by the Indian Health Service and in accordance with APL 17-020. Contractor shall adjust any payments to American Indian Health Service Programs if necessary to comply with any retroactive changes to the outpatient per-visit rates published in the Federal Register by the Indian Health Service.
 - b) Contractor shall reimburse American Indian Health Service Programs at the Medi-Cal FFS rate for services that, in accordance Supplement 6, Attachment 4.19-B of the California Medicaid State Plan, are not eligible for the outpatient per-visit rate published in the Federal Register by the Indian Health Service.

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

If there are no CNMs or CNPs in Contractor's Provider Network, Contractor shall reimburse non-contracting CNMs or CNPs for services provided to Members at no less than the applicable Medi-Cal FFS rates. If an appropriately licensed non-contracting facility is used, Contractor shall pay the facility fee. For hospitals, the requirements of Provision 13, Paragraph C. below apply. For birthing centers, the Contractor shall reimburse no less than the applicable Medi-Cal FFS rate.

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9. Non-Contracting Family Planning Providers' Reimbursement

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

10. Sexually Transmitted Disease (STD)

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

11. HIV Testing and Counseling

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

12. Immunizations

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

13. Contracting & Non-Contracting Emergency Service Providers & Post-Stabilization

A. Emergency Services: Contractor is responsible for coverage and payment of Emergency Services and post stabilization care services and must cover and pay for Emergency Services regardless of whether the Provider that furnishes the services has a contract with the plan. Contractor may not deny payment for treatment obtained when an enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 CFR 438.114(a) of the definition of emergency medical condition.

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Further, Contractor may not deny payment for treatment obtained when a representative of Contractor instructs the enrollee to seek Emergency Services.

- B. Contractor may not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms or refuse to cover Emergency Services based on the emergency room Provider, hospital, or fiscal agent not notifying the Member's Primary Care Provider, the plan, or DHCS of the enrollee's screening and treatment within ten (10) calendar days of presentation for Emergency Services. A Member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.
- C. Contractor shall pay for emergency services received by a Member from non-contracting Providers. Payments to non-contracting Providers shall be for the treatment of the emergency medical condition including Medically Necessary inpatient services rendered to a Member until the Member's condition has stabilized sufficiently to permit referral and transfer in accordance with instructions from Contractor or the Member is stabilized sufficiently to permit discharge. The attending emergency physician, or the Provider treating the Member is responsible for determining when the Member is sufficiently stabilized for transfer or discharge and that determination is binding on the Contractor. Emergency services shall not be subject to prior authorization by Contractor.
- D. At a minimum, Contractor must reimburse the non-contracting emergency department and, if applicable, its affiliated Providers for Physician Services at the lowest level of emergency department evaluation and management Physician's Current Procedural Terminology (CPT) codes, unless a higher level is clearly supported by documentation, and for the facility fee and diagnostic services such as laboratory and radiology.
- E. For all non-contracting Providers, reimbursement by Contractor, or by a Subcontractor who is at risk for out-of-Network emergency services, for properly documented claims for services rendered on or after January 1, 2007 by a non-contracting Provider pursuant to this provision shall be made in accordance with Provision 5. Claims Processing above and 42 USC Section 1396u-2(b)(2)(D).
- F. Contractor shall not refuse to cover reimbursement for Emergency Services rendered by a non-contracting Provider based on the emergency room Provider, hospital, or fiscal agent not notifying the Member's Primary Care Physician or Contractor of the Member's screening and treatment within ten (10) calendar days of presentation for emergency. Contractor shall not limit what constitutes and Emergency Medical Condition solely on the basis of lists of diagnoses or symptoms.

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- G. In accordance with California Code of Regulations, Title 28, Section 1300.71.4, Contractor shall approve or disapprove a request for post-stabilization inpatient services made by a non-contracting Provider on behalf of a Member within 30 minutes of the request. If Contractor fails to approve or disapprove authorization within the required timeframe, the authorization will be deemed approved.
- H. **Post Stabilization Services:** Post stabilization care services are covered and paid for in accordance with provisions set forth at 42 CFR 422.113(c). Contractor is financially responsible for post-stabilization services obtained within or outside Contractor's Network that are pre-approved by a plan Provider or other entity representative. Contractor is financially responsible for post-stabilization care services obtained within or outside Contractor's Network that are not pre-approved by a Network Provider or other Contractor representative, but administered to maintain the enrollee's stabilized condition within one (1) hour of a request to Contractor for pre-approval of further post-stabilization care services.
- I. Contractor is also financially responsible for post-stabilization care services obtained within or outside Contractor's Network that are not pre-approved by a Network Provider or other entity representative, but administered to maintain, improve or resolve the Member's stabilized condition if Contractor does not respond to a request for pre-approval within 30 minutes; Contractor cannot be contacted; or Contractor's representative and the treating Physician cannot reach an agreement concerning the Member's care and a plan Physician is not available for consultation. In this situation, Contractor must give the treating Physician the opportunity to consult with a Network Provider and the treating Physician may continue with care of the patient until a Network Provider is reached or one of the criteria of 42 CFR 422.133(c)(3) is met.
- J. Contractor's financial responsibility for post-stabilization care services it has not pre-approved ends when a Network Provider with privileges at the treating hospital assumes responsibility for the Member's care, a Network Provider assumes responsibility for the Member's care through transfer, a plan representative and the treating Physician reach an agreement concerning the Member's care; or the Member is discharged.
- K. Consistent with 42 CFR 438.114(e), 422.113(c)(2), and 422.214, Contractor is financially responsible for payment of post-stabilization services, following an emergency admission, at the hospital's Medi-Cal FFS payment amounts for general acute care inpatient services rendered by a non-contracting Medi-Cal certified hospital, unless a lower rate is agreed to in writing and signed by the hospital.
 - 1) For the purposes of this Paragraph K, the Medi-Cal FFS payment amounts for dates of service when the post-stabilization services

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were rendered shall be the Medi-Cal FFS payment amounts that are:

- a) Published in the annual All Plan Letter issued by the Department in accordance with California Welfare and Institutions Code Section 14091.3, which for the purposes of this Paragraph K shall apply to all acute care hospitals, including hospitals contracting with the State under the Medi-Cal Selective Provider Contracting Program (Welfare and Institutions Code Section 14081 et. seq.), less any associated direct or indirect medical education payments to the extent applicable, which Item a) shall be applicable until it is replaced by the implementation of the payment methodology in Item b) below.
 - b) Established in California Welfare and Institutions Code Section 14105.28, upon the Department's implementation of the payment methodology based on diagnosis-related groups, which for the purposes of this Paragraph K shall apply to all acute care hospitals, including public hospitals that are reimbursed under the Certified Public Expenditure Basis methodology (Welfare and Institutions Code Section 14166. et. seq.), less any associated direct or indirect medical education payments to the extent applicable.
- 2) Payment made by Contractor to a hospital that accurately reflects the payment amounts required by this Paragraph K shall constitute payment in full under this Paragraph K, and shall not be subject to subsequent adjustments or reconciliations by Contractor, except as provided by Medicaid and Medi-Cal law and regulations. A hospital's tentative and final cost settlement processes required by Title 22 CCR 51536 shall not have any effect on payments made by Contractor pursuant to this Paragraph K.
- L. Disputed emergency services claims may be submitted to DHCS, Office of Administrative Hearings and Appeals, 1029 J Street, Suite 200, Sacramento, California, 95814 for resolution under provisions of Welfare and Institutions Code Section 14454 and, Title 22 CCR, Section 53620 et. seq., except Section 53698. Contractor agrees to abide by the findings of DHCS in such cases, to promptly reimburse the non-contracting Provider within 30 calendar days of the effective date of a decision that Contractor is liable for payment of a claim and to provide proof of reimbursement in such form as the DHCS Director may require. Failure to reimburse the non-contracting Provider and provide proof of reimbursement to DHCS within 30 calendar days shall result in liability offsets in accordance with Welfare and Institutions Code Sections 14454(c) and 14115.5, and California Code of Regulations, Title 22 CCR, Section 53702.

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14. Provider-Preventable Conditions

Contractor shall not pay any provider claims nor reimburse a provider for a Provider-Preventable Condition (PPC), in accordance with 42 CFR 438.3(g). Contractor shall report, and require any and all of its Network Providers and Subcontractors to report, PPCs in the form and frequency required by APL 17-009.

15. Prohibition Against Payment of Excluded Providers

In accordance with Section 1903(i)(2) of the Act, Contractor shall not pay any amount for any Covered Service or item, other than Emergency Services, to an excluded provider as defined in Exhibit E, Attachment 2, Provision 26, Section B.8) of this Contract. This prohibition shall include services furnished by a Provider at the medical direction or by prescription of the excluded provider when the Provider knew or had a reason to know of the exclusion, or by an excluded provider to whom DHCS has failed to suspend payment while pending an investigation of a credible allegation of fraud.

16. Organ and Bone Marrow Transplants

In accordance with W&I Code section 14184.201(c), and for applicable dates of service, Contractor must reimburse a Provider furnishing organ or bone marrow transplant surgeries to a Member the amount the Provider could collect for those same services if the Member accessed those services in the Medi-Cal FFS delivery system, as defined by DHCS in the California Medicaid State Plan, a Directed Payment Initiative, and other applicable guidance, including but not limited to guidance issued pursuant to W&I Code section 14184.102(d).

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1. General Requirement

- A. Contractor shall ensure that each Member has a Primary Care Provider who is available and physically present at the service site for sufficient time to ensure access for the assigned Member when medically required. This requirement does not preclude an appropriately licensed professional from being a substitute for the Primary Care Provider in the event of vacation, illness, or other unforeseen circumstances.
- B. Contractor shall ensure Members access to Specialists for Medically Necessary Covered Services. Contractor shall ensure adequate staff within the Service Area, including physicians, administrative and other support staff directly and/or through Network Provider Agreements and Subcontractor Agreements, sufficient to assure that health services will be provided in accordance with Title 22 CCR Section 53853(a) and consistent with all specified requirements.
- C. If Contractor has an approved Alternate Access Standard (AAS) for a core Specialist Contractor is required assist any requesting Member in obtaining an appointment with an appropriate Out-Of-Network core Specialist, in person or via telehealth. When assisting the Member, Contractor must make its best effort to establish a Member-specific case agreement with an Out-Of-Network core Specialist at the Medi-Cal Fee-For-Service rate or a mutually agreed upon rate, unless Contractor has already attempted to establish a Member-specific case agreement with the Out-Of-Network core Specialist in the most recent fiscal year, and the core Specialist has refused to enter into an agreement.
 - 1) If this cannot be arranged, Contractor must arrange for an appointment with a Network Specialist.
 - 2) The Out-Of-Network core Specialist must be able to provide services to a Member within the applicable time or distance and timely access standards and, in cases where the Out-Of-Network Specialist is not able to provide services to a Member under these standards, Contractor must arrange for Non-Emergency Medical Transportation or Non-Medical Transportation.

2. Existing Member-Physician Relationships

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

3. Access Requirements

Contractor shall establish acceptable accessibility requirements in accordance with W&I Code Section 14197, Title 28 CCR Sections 1300.67.2.1 and

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1300.67.2.2, and as specified below. DHCS will review and approve requirements for reasonableness. Contractor shall communicate, enforce, and monitor Network Providers' compliance with these requirements.

A. Appointments

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

B. Waiting Times

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

C. Telephone Procedures

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

D. After Hours Calls

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

E. Unusual Specialty Services

Contractor shall arrange for the provision of seldom used or unusual specialty services from Specialists outside the Network if unavailable within Contractor's Network, when determined Medically Necessary.

4. Access Standards

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

A. Appropriate Clinical Timeframes

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

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B. Standards for Timely Appointments

Members must be offered appointments within the following timeframes:

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

C. Shortening or Expanding Timeframes

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

D. Provider Shortage

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

E. Call Center Wait Time Standards

Contractor shall ensure that, during normal business hours, the waiting time for a Member to speak by telephone with a Contractor's customer service representative who is knowledgeable and competent regarding the

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Member's questions and concerns shall not exceed ten (10) minutes as required by Title 28 CCR Section 1300.67.2.2(c)(10).

F. Nurse Triage Line Standards

Contractor shall provide or arrange for the provision, 24 hours per day, seven (7) days per week, of triage or screening services by telephone and shall ensure that telephone triage or screening services are provided in a timely manner appropriate for the Member's condition, and that the triage or screening waiting time does not exceed 30 minutes as required by Title 28 CCR Section 1300.67.2.2(c)(8).

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

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

6. Standing Referrals

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

- A. Contractor shall have in place a procedure for a Member to receive a standing referral to a Specialist if the primary care physician determines, in consultation with the Specialist and Contractor's Medical Director or the Medical Director's designee, that a Member needs continuing care from a Specialist. If a treatment plan is necessary in the course of care and is approved by Contractor, in consultation with the primary care physician, Specialist, and Member, a referral shall be made in accordance with the treatment plan. A treatment plan may be deemed unnecessary if Contractor approves a current standing referral to a Specialist. The treatment plan may limit the number of visits to the Specialist, limit the period of time that the visits are authorized, or require that the Specialist provide the primary care physician with regular reports on the health care provided to the Member.
- B. Contractor shall have in place a procedure for a Member with a condition or disease that requires specialized medical care over a prolonged period of time and is life-threatening, degenerative, or disabling to receive a referral to a Specialist or specialty care center that has expertise in treating the condition or disease for the purpose of having the Specialist coordinate the Member's health care. The referral shall be made if the Primary Care Physician, in consultation with the Specialist or specialty

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

- C. Determinations for standing referrals shall be made within three (3) business days from the date the request is made by the Member or the Member's primary care physician and all appropriate medical records and other items of information necessary to make the determination are provided. Once a determination is made, the referral shall be made within four (4) business days of the date the proposed treatment plan, if any, is submitted to Contractor's Medical Director or the Medical Director's designee.
- D. Standing referrals do not require Contractor to refer to a Specialist who, or to a specialty care center that, is not employed by or under contract with Contractor to provide health care services to Members, unless there is no Specialist within the Provider Network that is appropriate to provide treatment to Members, as determined by a primary care physician in consultation with Contractor's Medical Director as documented in the treatment plan.

7. Emergency Care

Contractor shall ensure that a Member with an emergency condition will be seen on an emergency basis and that emergency services will be available and accessible within the Service Area 24-hours-a-day.

- A. Contractor shall cover emergency medical services without prior authorization pursuant to Title 28 CCR, Section 1300.67(g)(1) and Title 22 CCR Sections 53216 and 53855. Contractor shall coordinate access to emergency care services in accordance with the Contractor's DHCS-approved emergency department protocol (see Exhibit A, Attachment 7, Provider Relations).
- B. Contractor shall ensure adequate follow-up care for those Members who have been screened in the emergency room and require non-emergency care.
- C. Contractor shall ensure that a plan or contracting physician is available 24 hours a day, seven (7) days a week, to authorize Medically Necessary post-stabilization care and coordinate the transfer of stabilized Members in an emergency department, if necessary.

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8. Nurse Midwife and Nurse Practitioner Services

Contractor shall meet Federal requirements for access to Certified Nurse Midwife (CNM) services as defined in Title 22 CCR Section 51345 and Certified Nurse Practitioner (CNP) services as defined in Title 22 CCR Section 51345.1. Contractor shall inform Members that they have a right to obtain Out-of-Network CNM services if not available in-Network.

9. Access to Services with Special Arrangements

A. Family Planning

Members have the right to access family planning services through any family planning Provider without prior authorization. Contractor shall provide family planning services in a manner that protects and gives Members the freedom to choose the method of family planning to be used consistent with 42 CFR 441.20. Contractor shall inform its Members in writing of their right to access any qualified family planning Provider without Prior Authorization in its Member Services Guide per Exhibit A, Attachment 13, Member Services.

1) Informed Consent

Contractor shall ensure that informed consent is obtained from Medi-Cal enrollees for all contraceptive methods, including sterilization, consistent with requirements of Title 22 CCR Sections 51305.1 and 51305.3.

2) Out-Of-Network Family Planning Services

Members of childbearing age may access the following services from Out-of-Network family planning Providers to temporarily or permanently prevent or delay pregnancy:

- a) Health education and counseling necessary to make informed choices and understand contraceptive methods.
- b) Limited history and physical examination.
- c) Laboratory tests if medically indicated as part of decision-making process for choice of contraceptive methods. Contractor shall not be required to reimburse Out-of-Network Providers for pap smears, if Contractor has provided pap smears to meet the U.S. Preventive Services Task Force guidelines.
- d) Diagnosis and treatment of a sexually transmitted disease episode, as defined by DHCS for each sexually transmitted

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disease, if medically indicated.

- e) Screening, testing, and counseling of at risk individuals for HIV and referral for treatment.
- f) Follow-up care for complications associated with contraceptive methods provided or prescribed by the family planning Provider.
- g) Provision of contraceptive pills, devices, and supplies.
- h) Tubal ligation.
- i) Vasectomies.
- j) Pregnancy testing and counseling.

B. Sexually Transmitted Diseases (STDs)

Contractor shall provide access to STD services without prior authorization to all Members both within and outside its Provider Network. Members may access out-of-Network STD services through local health department (LHD) clinics, family planning clinics, or through other community STD service Providers. Members may access LHD clinics and family planning clinics for diagnosis and treatment of a STD episode. For community Providers other than LHD and family planning Providers, out-of-Network services are limited to one office visit per disease episode for the purposes of: (1) diagnosis and treatment of vaginal discharge and urethral discharge, (2) those STDs that are amenable to immediate diagnosis and treatment, and this includes syphilis, gonorrhea, chlamydia, herpes simplex, chancroid, trichomoniasis, human papilloma virus, non-gonococcal urethritis, lymphogranuloma venereum and granuloma inguinale and (3) evaluation and treatment of pelvic inflammatory disease. Contractor shall provide follow-up care.

C. HIV Testing and Counseling

Members may access confidential HIV counseling and testing services through Contractor's Provider Network and through the Out-of-Network local health department and family planning Providers.

D. Minor Consent Services

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

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- 1) Sexual assault, including rape.
- 2) Drug or alcohol abuse for children 12 years of age or older.
- 3) Pregnancy.
- 4) Family planning.
- 5) Sexually transmitted diseases (STDs), designated by the Director, in children 12 years of age or older.
- 6) Outpatient mental health care for children 12 years of age or older who are mature enough to participate intelligently and where either (1) there is a danger of serious physical or mental harm to the minor or others, or (2) the children are the alleged victims of incest or child abuse.

E. Immunizations

Members may access LHD clinics for immunizations. Contractor shall, upon request, provide updated information on the status of Members' immunizations to the LHD clinic. The LHD clinic shall provide immunization records when immunization services are billed to the Contractor.

F. American Indian Health Services Programs

Contractor shall ensure Members have access to American Indian Health Services Programs pursuant to, and in compliance with all requirements of 42 USC Section 1396o(a), and Section 5006 of Title V of the American Recovery and Reinvestment Act of 2009. American Indian Health Service Programs, whether a Network Provider or Out-of-Network Provider, can provide referrals directly to Network Providers without first requesting a referral from a Network Primary Care Provider. Contractor shall ensure timely access to American Indian Health Service Programs by including American Indian Health Service Programs within Contractor's Network for American Indian Members, as well as permitting access to out-of-network American Indian Health Service Programs, in accordance with 42 CFR 438.14(b).

10. Changes in Availability or Location of Covered Services

- A. Contractor must provide notification to DHCS immediately upon discovery of a Provider initiated termination, or at least 60 calendar days before making any Significant Change in the availability or location of services to be provided under this Contract if it affects more than 2,000 Members or

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affects Contractor's ability to meet Network adequacy standards in accordance with APL 21-003. In the event of an emergency or other unforeseeable circumstances, Contractor must notify DHCS of the change in availability or location of services as soon as possible.

- B. Contractor must provide notification to DHCS immediately or within ten (10) calendar days of learning of a Provider's exclusionary status from any database or list included in APL 21-003.

11. Access for Members with Disabilities

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

12. Language and Communication Assistance

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

Contractor shall ensure equal access to health care services for Limited English Proficient (LEP) Members or Potential Enrollees and Members or Potential Enrollees with disabilities, through provision of high quality interpreter and linguistic services in compliance with federal and State law, and APL 20-015.

13. Cultural and Linguistic Program

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

- A. Written Description

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

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- 1) An organizational commitment to deliver culturally and linguistically appropriate health care services.
- 2) Goals and objectives.
- 3) A timetable for implementation and accomplishment of the goals and objectives.
- 4) An organizational chart showing the key staff persons with overall responsibility for cultural and linguistic services and activities. A narrative shall explain the chart and describe the oversight and direction to the Community Advisory Committee, provisions for support staff, and reporting relationships. Qualifications of staff, including appropriate education, experience and training shall also be described.
- 5) Standards and Performance requirements for the delivery of culturally and linguistically appropriate health care services.

B. Linguistic Capability of Employees

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

C. Population Needs Assessment (PNA)

Contractor shall conduct a PNA, as specified below, to identify the health education and cultural and linguistic needs of its' Members; and utilize the findings for continuous development and improvement of contractually required health education and cultural linguistic programs and services. Contractor must use multiple reliable data sources, methodologies, techniques, and tools to conduct the PNA.

- 1) Contractor shall submit an initial Population Health Management Strategy, informed by a PNA within 12 months from the commencement of operations within a Service Area and at least annually thereafter. For Contracts existing at the time this provision becomes effective, the next PNA will be required at a time within five (5) years from the effective date of this provision, to be determined by DHCS.
- 2) Contractor shall submit a PNA report to the DHCS every three years beginning in 2025 that must include:
 - a) The objectives; methodology; data sources; survey instruments; findings and conclusions; program and policy implications; and references contained in the PNA.

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- b) The findings and conclusions must include the following information for Medi-Cal plan Members: 1) demographic profile; 2) related health risks, problems and conditions; 3) related knowledge, attitudes and practices including cultural beliefs and practices; 4) perceived health education needs including learning needs, preferred methods of learning and literacy level; and 5) culturally competent community resources.
- 3) Contractor shall demonstrate that PNA report findings and conclusions in item 2) b) above are utilized for continuous development of its health education and cultural and linguistic services program. Contractor must maintain documentation of program priorities, target populations, and program goals/objectives as they are revised to meet the identified and changing needs of the Member population.
- D. The results of the PNA shall be considered in the development of any Marketing or promotional materials prepared by Contractor.
- E. Cultural Competency Training

Contractor shall provide cultural competency, sensitivity, or diversity training for staff, Network Providers, and Subcontractors at key points of contact. The training shall promote access and the delivery of services in a culturally competent manner to all Members, regardless of sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, or identification with any other persons or groups defined in Penal Code 422.56. The training shall cover information about the identified cultural groups in the Contractor's Service Areas, such as the groups' beliefs about illness and health; methods of interacting with Providers and the health care structure; traditional home remedies that may impact what the Provider is trying to do to treat the patient; and, language and literacy needs.

- F. Program Implementation and Evaluation

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

14. Linguistic Services

- A. Contractor shall comply, and ensure that its Network Providers and Subcontractors comply with 22 CCR Section 53853(c) and (d), 28 CCR

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Section 1300.67.04, W&I Code Section 14029.91 and 45 CFR 92.101, and ensure that all monolingual, non-English-speaking, or LEP Members and Potential Enrollees receive 24-hour oral interpreter services at all key points of contact, as defined in Paragraph D of this Provision, either through interpreters, telephone language services, or any electronic options Contractor chooses to utilize. Contractor shall ensure that lack of interpreter services does not impede or delay timely access to care.

- B. Contractor shall comply with 42 CFR 438.10(d)(3) and (4) and provide, at minimum, the following linguistic services at no cost to Medi-Cal Members or Potential Enrollees:
- 1) Oral Interpreters, sign language Providers, or bilingual Network Providers Network Provider staff, and Subcontractors, at all key points of contact. These services shall be provided in all languages spoken by Medi-Cal Members and Potential Enrollees and not limited to those that speak the threshold or concentration standards languages.
 - 2) Fully translated Member information, including but not limited to the Member Services Guide, welcome packets, marketing information, and form letters including NOA letters and Grievance and Appeal acknowledgement and resolution letters. Contractor shall provide translated written informing materials to all monolingual or LEP Members that speak the identified threshold or concentration standard languages. The threshold or concentration languages are identified by DHCS within Contractor's Service Area, and by Contractor in its PNA.
 - 3) Referrals to culturally and linguistically appropriate community service programs.
 - 4) Auxiliary Aids such as Telephone Typewriters (TTY)/ Telecommunication Devices for the Deaf (TDD) and American Sign Language, and, in accordance with written informing materials in alternative formats, selected by the Member, as specified in APL 21-004 and APL 22-002.
 - a) In determining what types of Auxiliary Aids and services to provide, Contractor must give primary consideration to a Member's request for a particular Auxiliary Aid or service.
 - b) In addition to Members and Potential Enrollees, Contractor must provide Auxiliary Aids and services to the Member's family, or a friend or associate, if required by the ADA. This includes an individual identified as the Member's authorized representative or as someone with whom it is appropriate for

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Contractor to communicate, such as a Member's disabled spouse.

- c) If a Member selects an electronic format, such as an audio or data CD, for any Member materials as identified in Exhibit A, Attachment 13, Provision 3 of this Contract, then Contractor may provide the materials in an unencrypted format but only with the Member's informed consent. If the Member requests a password-protected electronic format, Contractor must provide the materials as requested with unencrypted instructions on how the Member can access the encrypted information.

C. Contractor shall provide translated Member information to the following population groups within its Service Area as determined by DHCS:

- 1) A population group of Eligible Beneficiaries residing in Contractor's Service Area who indicate their primary language as a language other than English, and that meet a numeric threshold of 3,000 or five percent (5%) of the Eligible Beneficiaries population, whichever is lower.
- 2) A population group of Eligible Beneficiaries residing in Contractor's Service Area who indicate their primary language as a language 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.

D. Key points of contact include:

- 1) Medical care settings: telephone, advice and urgent care transactions, and outpatient encounters with health care Providers.
- 2) Non-medical care setting: Member services, orientations, and appointment scheduling.

15. Community Advisory Committee

Contractor shall form a Community Advisory Committee (CAC) pursuant to Title 22 CCR Section 53876 (c) that will implement and maintain community partnerships with consumers, community advocates, and Traditional and Safety-Net Providers. Contractor shall ensure that the CAC is included and involved in policy decisions related to Quality Improvement, educational, operational and cultural competency issues affecting groups who speak a primary language other than English.

16. Out-of-Network Providers

A. If Contractor's Network is unable to provide necessary services covered

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under the Contract to a particular Member, Contractor must adequately and timely cover these services out-of-Network for the Member, for as long as the entity is unable to provide them. Out-of-Network Providers must coordinate with the entity with respect to payment. Contractor must ensure that cost to the Member is not greater than it would be if the services were furnished within the Network.

- B. Contractor shall provide for the completion of covered services by a terminated or Out-of-Network Provider at the request of a Member in accordance with the continuity of care requirements in Health and Safety Code Section 1373.96.
- C. For newly enrolled SPD beneficiaries who request continued access, Contractor shall provide continued access for up to 12 months to an Out-of-Network Provider with whom they have an ongoing relationship if there are no quality of care issues with the Provider and the Provider will accept Contractor or Medi-Cal FFS rates, whichever is higher, in accordance with W&I Code section 14182(b)(13) and (14). An ongoing relationship shall be determined by Contractor identifying a link between a newly enrolled SPD beneficiary and an Out-of-Network Provider using FFS utilization data provided by DHCS.
- D. In determining access to Out-of-Network Providers for mental health or substance use disorder benefits, Contractor must use processes, strategies, evidentiary standards, or other factors that are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors for services identified within this Provision, in accordance with 42 CFR 438.910(d)(3).

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1. Covered Services

- A. Contractor shall provide or arrange for all Medically Necessary Covered Services for Members. Covered Services are those services set forth in Title 22 CCR Chapter 3, Article 4, beginning with Section 51301, Title 17, CCR, Division 1, Chapter 4, Subchapter 13, beginning with Section 6840, and provided in accordance 42 CFR 438.210(a) and 42 CFR 440.230, unless otherwise specifically excluded under the terms of this Contract. Contractor shall ensure that the Covered Services and other services required in this Contract are provided to a Member in an amount no less than what is offered to beneficiaries under FFS. Contractor has the primary responsibility to provide all Medically Necessary Covered Services, including services which exceed the services provided by Local Education Agencies (LEA), Regional Centers, or local governmental health programs.
- B. Contractor shall ensure that services provided are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the Covered Services are furnished, and may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. Contractor may place appropriate limits on a service on the basis of criteria such as Medical Necessity; or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose and the services supporting Members with ongoing or chronic conditions, or who require MLTSS, are provided in a manner that reflects the Member's ongoing needs.
- C. Except as set forth in Attachment 3.1.B.1 (effective 1/1/2006) of the California Medicaid State Plan or as otherwise authorized by W&I Code section 14133.23, effective January 1, 2006, for Full Benefit Dual Eligible Members who are eligible for drug benefits under Part D of Title XVIII of the Social Security Act (42 USC section 1395w-101 et seq), Part D eligible drugs are not a Covered Service under this Contract. Consequently, effective January 1, 2006, the capitation rates shall not include reimbursement for such drug benefits and existing capitation rates shall be adjusted accordingly, even if the adjustment results in a change of less than one (1) percent of cost to Contractor. Additionally, Contractor shall comply with all applicable provisions of the Medicare Prescription Drug Improvement and Modernization Act of 2003, 42 USC section 1395(x) et seq.
- D. In addition to services covered under the California Medicaid State Plan, Contractor shall cover any services necessary for compliance with the requirements for parity in mental health and substance use disorder benefits and ensure that Members are given access to all mental health and substance use disorder benefits in accordance with 42 CFR 438.900

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et seq. The types, amount, duration, and scope of these services must be consistent with the parity compliance analysis conducted by either DHCS or Contractor.

- 1) If Contractor provides Members with mental health or substance use disorder services in any classification of benefits as described in 42 CFR 439.910(b)(2), then Contractor must provide to Members those services in every classification that is listed therein and is covered by Contractor. In determining the classification in which a particular benefit belongs, Contractor must apply the same reasonable standards for medical/surgical benefits to mental health or substance use disorder benefits.
- 2) Contractor shall provide referrals for all non-covered mental health and substance use disorder services.

E. Medically Necessary Covered Services may be provided to Members through Telehealth, as defined in W&I 14132.72, APL 19-009.

2. Medically Necessary Services

For purposes of this Contract, the term “Medically Necessary” when applied to Members 21 years of age or older will include all Covered Services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness or injury, as required under W&I Code Section 14059.5(a) and Title 22 CCR Section 51303(a) Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.

For Members under 21 years of age, a treatment or service is Medically Necessary if it is necessary to correct or ameliorate defects and physical and mental illnesses or conditions under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard set forth in 42 USC Section 1396d(r)(5), as required by W&I Code Sections 14059.5(b)(1) and 14132(v), and as described in APL 19-010. Contractor shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child.

3. Initial Health Assessment (IHA)

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

A. Contractor shall cover and ensure the provision of an IHA (complete

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history and physical examination) in conformance with Title 22 CCR Section 53851(b)(1) to each new Member within timelines stipulated in Provision 5 and Provision 6 below.

- B. Contractor shall ensure that the IHA includes an IHEBA as described in Exhibit A, Attachment 10, Provision 8, Paragraph A, 10) using an age appropriate DHCS-approved assessment tool. Contractor is responsible for assuring that arrangements are made for follow-up services that reflect the findings or risk factors discovered during the IHA and IHEBA.
- C. Contractor shall ensure that Members' completed IHA and IHEBA tool are contained in the Members' medical record and available during subsequent preventive health visits.
- D. Contractor shall make reasonable attempts to contact a Member and schedule an IHA. All attempts shall be documented. Documented attempts that demonstrate Contractor's unsuccessful efforts to contact a Member and schedule an IHA shall be considered evidence in meeting this requirement.

4. Health Risk Stratification and Assessment for SPD Beneficiaries

Contractor shall apply a DHCS approved health risk stratification mechanism or algorithm to identify newly enrolled SPD beneficiaries with higher risk and more complex health care needs within 44 days of enrollment. Based on the results of the health risk stratification, Contractor shall also administer the DHCS approved health risk assessment survey within 45 days for SPD beneficiaries deemed to be at a higher health risk, and 105 days for those determined to be a lower health risk. The health risk stratification and assessment shall be done in accordance with W & I Code Sections 14182 (c)(11) to (13) and APL 17-013.

5. Services for Members under Twenty-One (21) Years of Age

Contractor shall cover and ensure the provision of all screening, preventive and Medically Necessary diagnostic and treatment services for Members under 21 years of age required under the EPSDT benefit described in 42 USC Section 1396d(r), and W&I Code section 14132(v). The EPSDT benefit includes all Medically Necessary health care, diagnostic services, treatments and other measures listed in 42 USC Section 1396d(a), whether or not covered under the State Plan. All EPSDT services are Covered Services, unless excluded under this Contract.

- A. Provision of IHAs for Members under Age 21
 - 1) For Members under the age of 18 months, Contractor shall ensure the provision of an IHA within 120 calendar days following the date of enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP) Bright Futures for ages two

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(2) and younger whichever is less.

- 2) For Members 18 months of age and older upon enrollment, Contractor is responsible to ensure an IHA is performed within 120 calendar days of enrollment.
- 3) The initial IHA assessment must include, or arrange for provision of, all immunizations necessary to ensure that the child is up-to-date for age, and an age appropriate IHEBA. See PL 13-001 for specific IHEBA requirements.

B. Children's Preventive Services

- 1) Contractor shall provide preventive health visits for all Members under 21 years of age at times specified by the most recent AAP Bright Futures periodicity schedule and anticipatory guidance as outlined in the AAP Bright Futures periodicity schedule. Contractor shall provide, as part of the periodic preventive visit, all age specific assessments and services required AAP Bright Futures and the age-specific IHEBA as necessary.
- 2) Where a request is made for children's preventive services by the Member, the Member's parent(s) or guardian or through a referral from the local Child Health and Disability Prevention (CHDP) program, an appointment shall be made for the Member to be examined within two (2) weeks of the request.
- 3) At each non-emergency primary care encounter with Members under the age of 21 years, the Member (if an emancipated minor) or the parent(s) or guardian of the Member shall be advised of the children's preventive services due and available from Contractor, if the Member has not received children's preventive services in accordance with AAP Bright Futures preventive standards. Documentation shall be entered in the Member's Medical Record which shall indicate the receipt of children's preventive services in accordance with the AAP Bright Futures standards or proof of voluntary refusal of these services in the form of a signed statement by the Member (if an emancipated minor) or the parent(s) or guardian of the Member. If the responsible party refuses to sign this statement, the refusal shall be noted in the Member's Medical Record.
- 4) All children's preventive services, including all confidential screening and billing reports for EPSDT screening, treatment and Care Coordination, shall be reported as part of the Encounter Data submittal required in Exhibit A, Attachment 3, Management Information System Capability, Provision 2. Encounter Data Submittal.

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C. Immunizations

Contractor shall ensure that all children receive necessary immunizations at the time of any health care visit. Contractor shall cover and ensure the timely provision of vaccines in accordance with the most recent childhood immunization schedule and recommendations published by the Advisory Committee on Immunization Practices (ACIP). Documented attempts that demonstrate Contractor's unsuccessful efforts to provide the immunization shall be considered sufficient in meeting this requirement.

If immunizations cannot be given at the time of the visit, the Member must be informed on how to obtain necessary immunizations or a scheduled and documented a future appointment for immunizations must be made at the time of that visit.

Appropriate documentation shall be entered in the Member's Medical Record indicating all attempts to provide immunization(s); instructions as to how to obtain necessary immunizations; the receipt of vaccines or proof of prior immunizations; or proof of voluntary refusal of vaccines in the form of a signed statement by the Member (if an emancipated minor) or the parent(s) or guardian of the Member. If the Member or authorized representative refuses to sign this statement, the refusal shall be noted in the Member's Medical Record.

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

Upon Federal Food and Drug Administration (FDA) approval of any vaccine for childhood immunization purposes, Contractor shall develop policies and procedures for the provision and administration of the vaccine. Contractor shall develop such policies and procedures within 30 calendar days of the vaccine's approval date. Contractor shall cover and ensure the provision of the vaccine from the date of its approval regardless of whether or not the vaccine has been incorporated into the Vaccines for Children (VFC) Program. Policies and procedures must be in accordance with any Medi-Cal FFS guidelines issued prior to final ACIP recommendations. Contractor shall provide information to all Network Providers regarding the VFC Program.

D. Screening for Childhood Lead Poisoning

- 1) Contractor shall cover and ensure the provision of blood lead screening tests to Members at the ages and intervals specified in

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Title 17 CCR, Division 1, Chapter 9, Articles 1 and 2, commencing with Section 37000, and in accordance with APL 20-016. Contractor shall ensure its Network Providers follow the Childhood Lead Poisoning Prevention Branch (CLPPB) guidelines when interpreting blood lead levels and determining appropriate follow-up activities.

While requirements for appropriate follow-up activities, including referral, case management, and reporting, are set forth in the CLPPB guidelines, a Network Provider may determine additional services that fall within the EPSDT benefit are Medically Necessary. Contractor must ensure that Members under the age of 21 receive all Medically Necessary care as required under EPSDT.

- 2) Contractor shall identify, on at least a quarterly basis, all Members under the age of six (6) with no record of receiving a required blood lead screening test. Contractor shall identify the age(s) at which a required blood lead screening test was missed, including Members under the age of six (6), without any record of a completed blood lead screening test at each age. On a quarterly basis, Contractor shall notify the Network Provider responsible for the care of an identified Member of the requirement to test the Member and provide the written or oral anticipatory guidance as required pursuant to Title 17 CCR Section 37100. For a period of no less than ten (10) years, Contractor shall maintain records of all Members identified quarterly as having no documentation of receiving a required blood lead screening test, and provide those records to DHCS at least annually, as well as upon request.
- 3) If the Member, or the Member's parent or guardian, refuses the blood lead screening test, Contractor shall ensure a signed statement of voluntary refusal by the Member (if an emancipated minor), or the parent or guardian of the Member, is documented in the Member's Medical Record.
- 4) If Contractor is unable to ensure a signed statement of voluntary refusal is documented in the Member's Medical Record because the Member, or the Member's parent or guardian refuses or declines to sign, or is unable to sign (e.g. when services are provided via telehealth modality), Contractor shall ensure that the reason for not obtaining a signed statement of voluntary refusal is documented in the Member's Medical Record.
- E. DHCS will consider unsuccessful attempts to provide the required blood lead screening tests that are documented in the Member's Medical Record in accordance with the requirements in Exhibit A, Attachment 10, Provision 5, Paragraph D, Screening for Childhood

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Lead Poisoning as evidence of Contractor's compliance with blood lead screening test requirements.

- E. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services
- 1) For Members under the age of 21 years, Contractor shall provide or arrange and pay for all preventive and Medically Necessary EPSDT services, which include any services set forth in 42 USC Section 1396d(a), unless otherwise carved out of this Contract, when the services are necessary to correct or ameliorate defects and physical and mental illnesses or conditions, regardless of whether such services are covered under the State Plan, as required by W&I Code Sections 14059.5(b)(1) and 14132(v), as described in APL 19-010. Covered Services shall include without limitation, in-home nursing provided by home health agencies or individual nurse providers, as required by APL 20-012, Care Coordination, case management, and Targeted Case Management (TCM) services as defined in Attachment 11, Provision 1 of this Contract. If Members under age 21 are not eligible for or accepted for Medically Necessary TCM services by a Regional Center or local government health program, Contractor shall ensure the Members' access to comparable services under the EPSDT benefit in accordance with APL 19-010.
 2. Contractor shall arrange for any Medically Necessary diagnostic and treatment services identified at a preventive screening or other visit indicating the need for diagnosis or treatment, either directly or through referral to appropriate agencies, organizations, or individuals, as required by 42 USC Section 1396a(a)(43)(C) and APLs 19-010 and 20-012. Contractor shall ensure that all Medically Necessary EPSDT services, including all Covered Services set forth in Provision 5, Paragraph E, Subparagraph 1 above, as well as EPSDT services carved out of this Contract, are provided in a timely manner, as soon as possible but no later than 60 calendar days following the preventive screening or other visit identifying a need for diagnosis or treatment. Without limitation, Contractor shall identify available Providers, including if necessary Out-of-Network Providers and individuals eligible to enroll as Medi-Cal Providers, to ensure the timely provision of Medically Necessary EPSDT services. Contractor shall provide appointment scheduling assistance and necessary transportation, including Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT), to and from medical appointments for Medically Necessary services, including all services available through the Medi-Cal program, whether or not they are Covered Services under this Contract.

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3. Covered Services do not include California Children's Services (CCS) pursuant to Exhibit A, Attachment 11, Provision 7, regarding CCS, or mental health services pursuant to Exhibit A, Attachment 11, Provision 4 (subject to Provision 8 below), regarding Specialty Mental Health Services. Contractor shall ensure that the case management for Medically Necessary services authorized by CCS or county mental health agencies under this paragraph is equivalent to that provided by Contractor for Covered Services for Members under the age 21 under this Contract and shall, if indicated or upon the Member's request provide additional Care Coordination and case management services as necessary to meet the Member's medical needs.

F. Behavioral Health Treatment (BHT) Services

For Members under 21 years of age, Contractor shall cover Medically Necessary BHT services regardless of diagnosis part of the EPSDT benefit.

- 1) Contractor shall provide Medically Necessary BHT services in accordance with recommendation from a licensed Physician and surgeon, or a licensed psychologist and shall provide continuation of BHT services under continuity of care.
- 2) The behavioral treatment plan must be reviewed, revised, and/or modified no less than every six (6) months by a BHT Provider. The behavioral treatment plan may be modified if Medically Necessary. BHT services may be discontinued when the treatment goals are achieved, goals are not met, or services are no longer Medically Necessary under the EPSDT medical necessity standard.
- 3) Contractor shall enter into a Memorandum of Understanding (MOU) with each local regional center in accordance with Exhibit A, Attachment 12, Provision 2 of this Contract, to facilitate the coordination of services for Members with developmental disabilities, including Autism Spectrum Disorder (ASD), as permitted by federal and State law, and specified by DHCS in APL 18-009. If Contractor is unable to enter into an MOU or a one-time case agreement, Contractor shall inform DHCS why it could not reach an agreement with the regional center and shall demonstrate, by providing all evidence of contracting efforts, a good faith effort to enter into an agreement with the regional center.

G. Rapid Whole Genome Sequencing

Rapid whole genome sequencing, including individual sequencing, trio sequencing for a parent or parents and their baby, and ultra-rapid

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sequencing, is a Covered Service for any Medi-Cal Member who is one (1) year of age or younger and is receiving inpatient hospital services in an intensive care unit as required in W&I Code section 14132(ae).

6. Services for Adults

A. IHAs for Adults (Age 21 and older)

- 1) Contractor shall cover and ensure that an IHA for adult Members is performed within 120 calendar days of enrollment.
- 2) Contractor shall ensure that the performance of the initial complete history and physical exam for adults includes, but is not limited to:
 - a) blood pressure,
 - b) height and weight,
 - c) total serum cholesterol measurement for men ages 35 and over and women ages 45 and over,
 - d) clinical breast examination for women over 40,
 - e) mammogram for women age 50 and over,
 - f) Pap smear (or arrangements made for performance) on all women determined to be sexually active,
 - g) Chlamydia screen for all sexually active females aged 21 and older who are determined to be at high-risk for chlamydia infection using the most current CDC guidelines. These guidelines include the screening of all sexually active females aged 21 through 25 years of age,
 - h) screening for TB risk factors including a Mantoux skin test on all persons determined to be at high risk, and,
 - i) IHEBA.

B. Adult Preventive Services

Contractor shall cover and ensure the delivery of all preventive services and Medically Necessary diagnostic and treatment services for adult Members.

- 1) Contractor shall ensure that the latest edition of the Guide to Clinical Preventive Services published by the U.S. Preventive Services Task Force (USPSTF) is used to determine the provision of clinical preventive services to asymptomatic, healthy adult

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Members [age 21 or older]. All preventive services identified as USPSTF “A” and “B” recommendations must be provided. For tobacco use prevention and cessation services, Contractor may use either the USPSTF recommendations or the latest edition of the US Public Health Service “Treating Tobacco Use and Dependence: A Clinical Practice Guideline.” As a result of the IHA or other examination, discovery of the presence of risk factors or disease conditions will determine the need for further follow-up, diagnostic, and/or treatment services. In the absence of the need for immediate follow-up, the core preventive services identified in the requirements for the IHA for adults described above shall be offered in the frequency required by the USPSTF Guide to Clinical Preventive Services.

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

C. Immunizations

Contractor is responsible for assuring that all adults are fully immunized. Contractor shall cover and ensure the timely provision of vaccines in accordance with the recent recommendations published by ACIP.

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

Contractor shall document attempts to provide immunizations. If the Member refuses the immunization, proof of voluntary refusal of the immunization in the form of a signed statement by the Member or guardian of the Member shall be documented in the Member’s Medical Record. If the responsible party refuses to sign this statement, the refusal shall be noted in the Member’s Medical Record. Documented attempts that demonstrate Contractor’s unsuccessful efforts to provide the immunization shall be considered evidence in meeting this requirement.

7. Pregnant Women

A. Prenatal Care

Contractor shall cover and ensure the provision of all Medically Necessary services for pregnant women. Contractor shall ensure that the most

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current standards or guidelines of the American College of Obstetricians and Gynecologists (ACOG) are utilized to provide, at a minimum, quality perinatal services.

B. Risk Assessment

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

C. Referral to Specialists

Contractor must ensure that pregnant Members are referred to medically appropriate Specialists, including, as appropriate, perinatologists, Freestanding Birthing Centers, Certified Nurse Midwives, and Licensed Midwives. In addition, Contractor must ensure that postpartum Members have access to genetic screening with appropriate referrals. Contractor must also ensure that appropriate hospitals are available within the Network to provide necessary high-risk pregnancy services.

8. Services for All Members

A. Health Education

- 1) Contractor shall implement and maintain a health education system that includes programs, services, functions, and resources necessary to provide health education, health promotion and patient education for all Members.
- 2) Contractor shall ensure administrative oversight of the health education system by a qualified full-time health educator.
- 3) Contractor shall provide health education programs and services at no charge to Members directly and/or through contracts with Providers that have expertise in delivering health education services to the Member population.
- 4) Contractor shall ensure the organized delivery of health education programs using educational strategies and methods that are appropriate for Members and effective in achieving behavioral

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change for improved health.

- 5) Contractor shall ensure that health education materials are written at the sixth grade reading level and are culturally and linguistically appropriate for the intended audience.
- 6) Contractor shall maintain a health education system that provides educational interventions addressing the following health categories and topics:
 - a) Appropriate use of health care services – managed health care; preventive and primary health care; obstetrical care; health education services; and, complementary and alternative care.
 - b) Risk-reduction and healthy lifestyles – tobacco use and cessation; alcohol and drug use; injury prevention; prevention of sexually transmitted diseases; HIV and unintended pregnancy; nutrition, weight control, and physical activity; and, parenting.
 - c) Self-care and management of health conditions – pregnancy; asthma; diabetes; and, hypertension.
- 7) Contractor shall ensure that Members receive point of service education as part of preventive and primary health care visits. Contractor shall provide education, training, and program resources to assist contracting medical Providers in the delivery of health education services for Members.
- 8) Contractor shall maintain health education policies and procedures, and standards and guidelines; conduct appropriate levels of program evaluation; and, monitor performance of Providers that are contracted to deliver health education services to ensure effectiveness.
- 9) Contractor shall periodically review the health education system to ensure appropriate allocation of health education resources, and maintain documentation that demonstrates effective implementation of the health education requirements.
- 10) Contractor shall ensure that all new Members complete the IHEBA within 120 calendar days of enrollment as part of the IHA; and that all existing Members complete the IHEBA at their next non-acute care visit. Contractor shall ensure: 1) that Primary Care Providers use the DHCS standardized “Staying Healthy” assessment tools, or alternative approved tools that comply with DHCS approval criteria for the IHEBA; and 2) that the IHEBA tool is: a) administered and

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reviewed by the Primary Care Provider during an office visit, b) reviewed at least annually by the Primary Care Provider with Members who present for a scheduled visit, and c) re-administered by the Primary Care Provider at the appropriate age-intervals.

- 11) Contractor shall cover and ensure provision of comprehensive case management including coordination of care services as described in Exhibit A, Attachment 22.
- 12) Contractor shall develop a referral policy to ensure the Member is seen by a dental Provider following an initial dental health screening. The Member shall be referred to a dental Provider to address any immediate dental needs and for comprehensive dental care which will include a comprehensive oral exam.

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

Contractor shall use data from a Health Information Form (HIF)/Member Evaluation Tool (MET) to help identify newly enrolled Members who may need expedited services. In accordance with 42 CFR section 438.208(b), Contractor shall, at a minimum, comply with the following:

- 1) Mail a DHCS-approved HIF/MET to all new Members as a part of Contractor's welcome packet and include a postage paid envelope for response.
- 2) Within 90 days of each new Member's effective date of enrollment:
 - a) Make at least two (2) telephone call attempts to remind new Members to return the HIF/MET and/or collect the HIF/MET information from new Members. This outreach can be done through head of household for Members under the care of parents, custodial parents, legal guardians, or other authorized representatives in accordance with applicable privacy laws.
 - b) Conduct an initial screening of the Member's needs as identified in the HIF/METs received. To meet this requirement, Contractor may build upon any existing screening process currently used to meet requirements in Exhibit A, Attachment 10, Scope of Services, or Exhibit A, Attachment 11, Case Management and External Coordination of Care.
- 3) Upon a Member's disenrollment, Contractor shall make the HIF/MET assessment results available to their new Medi-Cal Managed Care Health Plan upon request.

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C. Hospice Care

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

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

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

D. Vision Care - Lenses

Contractor shall cover and ensure the provision of eye examinations and prescriptions for corrective lenses as appropriate for all Members. Contractor must arrange for the fabrication of optical lenses for Members through Prison Industry Authority (PIA) optical laboratories, except when the Member requires lenses not available through PIA. Contractor's responsibility to arrange for the fabrication of optical lenses for Members through PIA optical laboratories shall be limited to Medi-Cal covered optical and optical lab services. Contractor shall cover the cost of the eye examination and dispensing of the lenses fabricated by PIA. DHCS will reimburse PIA for the fabrication of the optical lenses in accordance with the contract between DHCS and PIA. Contractor must cover the cost of lens material, fabrication, and dispensing of lenses not available through

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PIA.

E. Behavioral Health Services

- 1) Contractor shall cover mild to moderate Non-Specialty Mental Health Services (NSMHS) that are within the scope of practice of Primary Care Providers and mental health care Providers. Contractor shall refer Members needing Specialty Mental Health Services to the county mental health plan. Contractor's policies and procedures shall define and describe the services are to be provided by Primary Care Providers and mental health care Providers.
- 2) Contractor shall cover and pay for all Medically Necessary Mental Health Covered Services for the Member, including the following services:
 - a) Emergency room professional services as described in 22 CCR section 53855, 22 CCR section 53216, and 28 CCR section 1300.67(g). The requirement to provide emergency room professional services also includes all professional, physical, mental, and substance use disorder treatment services, including screening examinations necessary to determine the presence or absence of an Emergency Medical Condition and, if an Emergency Medical Condition exists, for all services Medically Necessary to stabilize the Member. Emergency Services includes Facility and professional services and facility charges claimed by emergency departments.
 - b) Facility charges for emergency room visits which do not result in a psychiatric admission.
 - c) All laboratory and radiology services when these services are necessary for the diagnosis, monitoring, or treatment of a Member's mental health condition.
 - d) Emergency Medical Transportation services necessary to provide access to all Medi-Cal Covered Services, including emergency mental health services, as described in Title 22 CCR Section 51323.
 - e) All NEMT services, as provided for in Title 22 CCR Section 51323, required by Members to access Medi-Cal covered mental health and substance use disorder services. These services include outpatient opioid detoxification, tobacco cessation, and Alcohol Misuse Screening and Counseling (AMSC) services, and are subject to a written prescription by

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Contractor's mental health or substance use disorder Provider within Contractor's mental health and substance use disorder Provider Network. NEMT services are subject to a written prescription and Prior Authorization, except for NEMT services provided between acute care hospitals immediately following an emergency room visit from which an inpatient transfer is occurring, or an inpatient stay at the acute level of care to imbedded psychiatric units, free standing psychiatric inpatient hospitals, psychiatric health facilities, and any other appropriate inpatient acute psychiatric facilities. The written prescription must be contained in a Physician Certification Statement form, which must be completed by a Member's Provider to request NEMT.

- f) Medically Necessary Covered Services after Contractor has been notified by a Specialty Mental Health Provider that a Member has been admitted to an inpatient psychiatric facility, including an Institution for Mental Diseases (IMD) as defined by Title 9 CCR Section 1810.222.1, regardless of the age of the Member. These services include, but are not limited to:
 - i The initial health history and physical examination required upon admission and any consultations related to Medically Necessary Covered Services.
 - ii. Notwithstanding this requirement, Contractor shall not be responsible for room and board charges for psychiatric inpatient hospital stays by Members.
 - iii. When IMD services are provided to Members age 21 and under or age 65 and over, Contractor shall cover Skilled Nursing Facility (SNF) room and board. Contractor shall not cover other inpatient psychiatric facility/IMD room and board charges or other services that are reimbursed as part of the inpatient psychiatric facility/IMD per diem rate.
- g) All Medically Necessary Medi-Cal covered psychotherapeutic drugs not otherwise excluded under this Contract, when administered in the outpatient setting as part of medical services.
 - i. This includes reimbursement for all Medically Necessary Medi-Cal covered psychotherapeutic drugs not otherwise excluded under this Contract, when administered in the outpatient setting as part of

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medical services by Out-of-Network Providers.

- ii. All reimbursement for psychotherapeutic drugs billed on a pharmacy claim for pharmacies enrolled in Medi-Cal shall be provided through the Medi-Cal FFS program. To qualify for reimbursement under this provision, a pharmacy must be enrolled as a Medi-Cal Provider in the Medi-Cal FFS program.
- h) Paragraphs c), e), and f) above shall not be construed to preclude Contractor from: (1) requiring that Covered Services be provided through Contractor's Provider Network, to the extent possible, or (2) applying utilization review controls for these services, including prior authorization, consistent with Contractor's obligation to provide Covered Services under this Contract.
- 3) Contractor shall develop and implement a written internal policy and procedure to ensure that Members who need Specialty Mental Health Services are referred to and are provided mental health services by an appropriate Medi-Cal FFS mental health Provider or to the county mental health plan for Specialty Mental Health Services in accordance with Exhibit A, Attachment 11, Case Management and External Coordination of Care, Provision 4. Specialty Mental Health.
- 4) Contractor shall establish and maintain mechanisms to identify Members who require non-covered psychiatric services and ensure appropriate referrals are made. Contractor shall continue to cover and ensure the provision of primary care and other services unrelated to the mental health treatment and coordinate services between the Primary Care Provider and the psychiatric service Provider(s). Contractor shall enter into a Memorandum of Understanding with the county mental health plan in accordance with Exhibit A, Attachment 12, Local Health Department Coordination, Provision 3. County Mental Health Plan Coordination.

F. Pharmaceutical Services

1) Drug Utilization Review (DUR)

Contractor shall develop and implement an effective DURs and treatment outcome processes, as directed in APL 17-008, APL 19-012, and APL 22-012 (excluding prospective DUR activities), to ensure that drug utilization is appropriate, Medically Necessary, and not likely to result in adverse events.

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- a) Contractor's DUR must meet or exceed the requirements described in 42 CFR section 438.3(s) and 42 USC section 1396r-8(g), to the extent that Contractor provides covered outpatient drugs, and Section 1004 requirements of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patient and Communities Act.
 - b) Contractor's DUR must implement:
 - i. A retrospective claims review automated process that monitors when a Member is concurrently prescribed opioids and benzodiazepines or opioids and antipsychotics;
 - ii. A program to monitor and manage the appropriate use of antipsychotic medications by all children 18 years of age and under including foster children enrolled under the California Medicaid State Plan, as required in 42 USC section 1396a(o)(1)(B) and superseding the requirements of APL 19-012 and APL 22-012; and
 - iii. Fraud and abuse identification processes for potential fraud or abuse of controlled substances by Members, Providers, and pharmacies.
 - c) Contractor shall annually submit to DHCS a detailed report on their DUR Program activities in a format specified by DHCS.
- 2) Contractor shall not impose QTL or NQTL more stringently for mental health and substance use disorder drugs than for medical/surgical drugs prescriptions in accordance with 42 CFR section 438.900 et. seq.
- G. Transportation
- Contractor shall cover transportation services as required in this Contract and directed in APL 22-008 to ensure Members have access to all Medically Necessary services.
- 1) Contractor shall cover Emergency Medical Transportation services necessary to provide access to all Medi-Cal Covered Services as described in Title 22 CCR Section 51323
 - 2) Contractor shall cover NEMT services necessary for Members to

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access Covered Services, subject to a Prior Authorization when required, in accordance with 22 CCR section 51323, and pharmacy services for all prescriptions that are prescribed by the Member's Provider(s) and authorized under Medi-Cal Rx. In addition, Contractor's Physician Certification Statement form must be completed by the Member's Provider to request NEMT services. Contractor shall refer and coordinate NEMT for all other Medi-Cal services not covered in this Contract.

- 3) As provided for in W&I Code section 14132(ad), Contractor shall authorize all NMT for Members to obtain Medically Necessary Covered Services in accordance with the requirements and guidelines set forth in APL 22-008. Nothing in this Provision should be construed to prohibit Contractor from developing policies and procedures that may include Prior Authorization requirements for NMT. Contractor must also provide NMT for all Medi-Cal services not covered under this Contract. These services include, but are not limited to, Specialty Mental Health Services, substance use disorder, dental, pharmacy, pharmaceutical services, and any other benefits delivered through Medi-Cal FFS.

H. Practice Guidelines

Contractor shall adopt practice guidelines in accordance with 42 CFR section 438.236, and this Contract. Contractor's decisions for utilization management, Member education, provision of Covered Services, and other areas covered by practice guidelines shall be consistent with these guidelines. Contractor shall also provide their practice guidelines, upon request, to Members and Potential Enrollees.

I. Organ and Bone Marrow Transplant Surgeries

Contractor must cover all Medically Necessary organ and bone marrow transplant surgeries as set forth in the Medi-Cal Provider Manual, including all updates and amendments to the Manual.

- 1) Contractor must refer and authorize organ and bone marrow transplant surgeries to be performed in transplant programs that meet criteria set forth by DHCS in the Medi-Cal Provider Manual.
- 2) Contractor must refer Members identified as potential organ or bone marrow transplant candidates to a transplant program evaluation that meets criteria set forth by DHCS within 72 hours of receiving the referral. If the transplant program considers the Member to be a suitable transplant candidate, Contractor must authorize the request for transplant services on an expedited 72-hour basis or less if the Member's condition requires it, or if the

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organ or bone marrow the Member will receive is at risk of being unusable due to any delay in obtaining prior authorization or any delay in obtaining the organ or bone marrow.

- 3) Contractor must refer Members under 21 years of age and identified as a potential organ or bone marrow transplant candidate to the local CCS Program for eligibility if necessary.
- 4) Contractor must refer Members under 21 years of age to the appropriate CCS-approved Special Care Center that meets criteria set forth by DHCS within 72 hours of receiving the referral from the Member's PCP or Specialist identifying the Member as a transplant candidate. If the CCS-approved Special Care Center considers the Member to be a suitable transplant candidate, Contractor is required to approve the Prior Authorization request.
- 5) For Members under 21 years of age, Contractor must provide Prior Authorization for requests for transplant services on an expedited, 72-hour basis, or less if the Member's condition requires it or if the organ or bone marrow the Member will receive is at risk of being unusable due to any delay in obtaining Prior Authorization or any delay in obtaining the organ or bone marrow.
- 6) Contractor must authorize and cover costs for organ or bone marrow donors, including cadavers and living donors regardless of a living donor's Medi-Cal eligibility. Contractor must cover transplant-related costs such as evaluation, hospitalization for the living donor, organ or bone marrow removal, and all Medically Necessary services related to organ or bone marrow removal including complications, transportation, and prescriptions not covered by and billable to Medi-Cal Rx.
- 7) Contractor must ensure coordination of care between all Providers, organ or bone marrow donation entities, and transplant centers to ensure the transplant is completed as expeditiously as possible. This coordination of care must include care for all living donors.
- 8) Contractor must ensure the provision of Discharge Planning as defined in this Contract for Members and living donors.
- 9) Contractor must cover all readmissions and other health care costs related to any complications the Member or the living donor experiences from the organ or bone marrow transplant.
- 10) Contractor must cover all Medically Necessary Physician administered drugs billed on a medical claim needed for the Member receiving an organ or bone marrow transplant, such as

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anti-rejection medication, and any other Medically Necessary prescription drug not covered by Medi-Cal Rx.

9. Investigational Services

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

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CASE MANAGEMENT AND EXTERNAL COORDINATION OF CARE

1. Targeted Case Management Services

Contractor is responsible for determining whether a Member requires Targeted Case Management (TCM) services, and must refer Members who are eligible for TCM services to a Regional Center or local governmental health program as appropriate for the provision of TCM services.

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

If Members under age 21 are not accepted for TCM services, Contractor shall ensure the Members' access to services are comparable to EPSDT TCM services per Exhibit A, Attachment 10, Scope of Services, Provision 5. Services for Members under Twenty-One (21) Years of Age.

2. Disease Management Program

Contractor is responsible for initiating and maintaining a disease management program. Contractor shall determine the program's targeted disease conditions and implement a system to identify and encourage Members to participate.

3. Out-of-Network Case Management and Coordination of Care

Contractor shall implement procedures to identify individuals who may need or who are receiving services from Out-of-Network Providers and/or programs in order to ensure coordinated service delivery and efficient and effective joint case management for services presented in Provisions 4 through 15 below.

4. Specialty Mental Health

A. Specialty Mental Health Services

- 1) All Specialty Mental Health Services (inpatient and outpatient) are excluded from this Contract.
- 2) Contractor shall make appropriate referrals for Members needing Specialty Mental Health Services as follows:
 - a) For those Members with a tentative psychiatric diagnosis which meets eligibility criteria for referral to the county mental health plan, as defined in PL 00-001 Revised and APL 13-021, the Member shall be referred to the county mental health plan in accordance with the Memorandum of Understanding (MOU) between Contractor and the county mental health plan and APL 13-018.

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- b) For those Members whose mental health diagnosis is not covered by the county mental health plan because the adult Member's level of impairment is mild to moderate, or the recommended treatment for adult and child Members do not meet the criteria for Specialty Mental Health Services, the Member shall be referred to an appropriate Medi-Cal mental health Provider within Contractor's Provider Network. Contractor shall consult with the county mental health plan as necessary to identify other appropriate community resources and to assist the Member to locate available non-covered mental health services.

- 3) Disputes between Contractor and the county mental health plan regarding this section shall be addressed collaboratively within the Contract as specified by the MOU to achieve a timely and satisfactory resolution. If Contractor and the county mental health plan cannot agree, disputes shall be resolved pursuant to Title 9, CCR, Section 1850.505. Any decision rendered by DHCS regarding a dispute between Contractor and the county mental health plan concerning provision of mental health services or Covered Services required under this Contract shall not be subject to the dispute procedures specified in Exhibit E, Attachment 2, Provision 18 regarding Disputes.

B. County Mental Health Plan Coordination

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

5. Alcohol and Substance Use Disorder Treatment Services

Alcohol and substance use disorder treatment services available under Drug Medi-Cal program as defined in Title 22 CCR 51341.1, and outpatient heroin detoxification services defined in Title 22 CCR 51328 are excluded from this Contract. These Excluded Services include all medications used for the treatment of alcohol and substance use disorders covered by DHCS, as well as specific medications not currently covered by DHCS, but reimbursed through the Medi-Cal FFS Program.

Contractor shall identify individuals requiring alcohol and or substance use disorder treatment services and refer the individuals to the county department responsible for substance use treatment, or other community resources when services are not available through counties, and to outpatient heroin detoxification Providers available through the Medi-Cal FFS program, for appropriate services. Contractor shall assist Members in locating available

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treatment service sites. To the extent that treatment slots are not available within Contractor's Service Area, Contractor shall pursue placement outside the area. Contractor shall continue to cover and ensure the provision of primary care and other services unrelated to the alcohol and substance use disorder treatment and coordinate services between the its Network Providers and the treatment programs.

Contractor shall execute a MOU with the county department for alcohol and substance use disorder treatment services.

6. Services for Children with Special Health Care Needs

Children with Special Health Care Needs (CSHCN) “those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional conditions and who also require health or related services of a type or amount beyond that required by children generally”.

Contractor shall implement and maintain a program for CSHCN which includes, but is not limited to, the following:

- A. Standardized procedures for the identification of CSHCN, at enrollment and on a periodic basis thereafter;
- B. Methods for ensuring and monitoring timely access to pediatric Specialists, sub-Specialists, ancillary therapists, and specialized equipment and supplies; these may include assignment to a Specialist as PCP, standing referrals, or other methods as defined by Contractor;
- C. Methods for ensuring that each CSHCN receives a comprehensive assessment of health and related needs, and that all Medically Necessary follow-up services are documented in the medical record, including needed referrals;
- D. A program for case management or care coordination for CSHCN, including coordination with other agencies which provide services for children with special health care needs (e.g. mental health, substance use disorder, Regional Center, CCS, local education agency, child welfare agency); and
- E. Methods for monitoring and improving the quality and appropriateness of care for children with special health care needs.

7. California Children's Services (CCS)

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

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- A. Contractor shall develop and implement written policies and procedures for identifying and referring children with CCS-eligible conditions to the local CCS program. The policies and procedures shall include, but not be limited, to those which:
- 1) Ensure that Contractor's Network Providers perform appropriate baseline health assessments and diagnostic evaluations which provide sufficient clinical detail to establish, or raise a reasonable suspicion, that a Member has a CCS-eligible medical condition;
 - 2) Assure that Network Providers understand that CCS reimburses only CCS-paneled Providers and CCS-approved hospitals within Contractor's Network; and only from the date of referral;
 - 3) Enable initial referrals of Member's with CCS-eligible conditions to be made to the local CCS program by telephone, same-day mail or fax, if available. The initial referral shall be followed by submission of supporting medical documentation sufficient to allow for eligibility determination by the local CCS program.
 - 4) Ensure that Contractor continues to provide all Medically Necessary Covered Services to the Member until CCS eligibility is confirmed.
 - 5) Ensure that, once eligibility for the CCS program is established for a Member, Contractor shall continue to provide all Medically Necessary Covered Services that are not authorized by CCS and shall ensure the coordination of services and joint case management between its Primary Care Providers, the CCS specialty Providers, and the local CCS program. Contractor shall continue to provide case management services to ensure all Medically Necessary treatment authorized through the CCS program is timely provided as required in Exhibit A, Attachment 10, Scope of Services, Provision 5. Services for Members under Twenty-One (21) Years of Age. Without limitation, Contractor shall, as necessary, or upon a Member's request, arrange for all in-home nursing hours authorized by the CCS program that a Member desires to utilize, as required by APL 20-012.
 - 6) If the local CCS program does not approve eligibility, Contractor remains responsible for the provision of all Medically Necessary Covered Services to the Member. If the local CCS program denies authorization for any service, Contractor remains responsible for obtaining the service, if it is Medically Necessary, and paying for the service if it has been provided.
- B. Contractor shall execute a Memorandum of Understanding (MOU) with the local CCS program as stipulated in Exhibit A, Attachment 12, Provision 2,

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for the coordination of CCS services to Members.

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

Authorization for payment shall be retroactive to the date the CCS program was informed about the Member through an initial referral by Contractor or a Network Provider, via telephone, fax, or mail. In an emergency admission, Contractor or Network Provider shall be allowed until the next Working Day to inform the CCS program about the Member. Authorization shall be issued upon confirmation of panel status or completion of the process described above.

8. Services for Persons with Developmental Disabilities

- A. Contractor shall develop and implement procedures for the identification of Members with developmental disabilities.
- B. Contractor shall maintain a dedicated liaison to coordinate with each regional center operating within the plan's service area to assist Members with developmental disabilities in understanding and accessing services and act as a central point of contact for questions, access and care concerns, and problem resolution as required by W & I Code Section 14182(c)(10).
- C. Contractor shall refer Members with developmental disabilities to a Regional Center for the developmentally disabled for evaluation and for access to those non-medical services provided through the Regional Centers, such as but not limited to, respite, out-of-home placement, and supportive living. Contractor shall participate with Regional Center staff in the development of the individual developmental services plan required for all persons with developmental disabilities, which includes identification of all appropriate services, including medical care services and Medically Necessary Non-Specialty Mental Health Services (NSMHS), which need to be provided to the Member.
- D. Contractor shall refer to Provision 18, Home and Community-Based Services Programs, of this Attachment for further coordination of care requirements related to providing Home and Community-Based Services (HCBS) through the HCBS-DD Waiver.

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

9. Early Intervention Services

Contractor shall develop and implement systems to identify children who may be eligible to receive services from the Early Start program and refer them to the local Early Start program. These children would include those with a condition known to lead to developmental delay, those in whom a significant developmental delay is suspected, or whose early health history places them at risk for delay. Contractor shall collaborate with the local Regional Center or local Early Start program in determining the Medically Necessary diagnostic and preventive services and treatment plans for Members participating in the Early Start program. Contractor shall provide case management and care coordination to the Member to ensure the provision of all Medically Necessary covered diagnostic, preventive and treatment services identified in the individual family service plan developed by the Early Start program, with Primary Care Provider participation.

10. Local Education Agency Services

LEA assessment services are services specified in Title 22, CCR Section 51360(b) and provided to students who qualify based on Title 22 CCR Section 51190.1. LEA services provided pursuant to an Individual Education Plan as set forth in Education Code, Section 56340 et seq. or Individual Family Service Plan as set forth in Government Code Section 95020 are not covered under this Contract. However, Contractor is responsible for providing a PCP and all Medically Necessary Covered Services for the Member, and shall ensure that the Member's PCP cooperates and collaborates in the development of the Individual Education Plan or the Individual Family Service Plan. Contractor shall provide case management and care coordination to the Member to ensure the provision of all Medically Necessary diagnostic, preventive and treatment services identified in the Individual Education Plan developed by the LEA, with Primary Care Provider participation.

11. School Linked CHDP Services

- A. Coordination of Care

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

- B. Cooperative Arrangements

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

- 1) Cooperative arrangements (e.g. Network Provider Agreements and Subcontractor Agreements) with school districts or school sites to directly reimburse schools for the provision of some or all of the CHDP services, including guidelines for sharing of critical medical information. The arrangements shall also include guidelines specifying coordination of services, reporting requirements, quality standards, processes to ensure services are not duplicated, and processes for notification to Member/student/parent on where to receive initial and follow-up services.
- 2) Cooperative arrangements whereby Contractor agrees to provide or contribute staff or resources to support the provision of school linked CHDP services.
- 3) Referral protocols/guidelines between Contractor and the school sites, which merely screen, for the need of CHDP services, including strategies for Contractor to follow-up and document if services are being provided to the Member within the required State and Federal time frames.
- 4) Any innovative approach that Contractor may develop to assure access to CHDP services and coordination with and support for school based health care services.

C. Network Provider Agreements and Subcontractor Agreements

Contractor shall ensure that the Network Provider Agreements and Subcontractor Agreements with the local school districts or school sites meet the requirements of Exhibit A, Attachment 6, Provision 14, regarding Network Provider Agreements and Subcontractor Agreements, and address the following: the population covered, beginning and end dates of the agreement, services covered, practitioners covered, outreach, information dissemination, educational responsibilities, utilization review requirements, referral procedures, medical information flows, patient information confidentiality, quality assurance interface, data reporting requirements, and Grievance and Appeal procedures.

12. Dental

Contractor shall cover and ensure that dental screenings and oral health assessments for all Members are included as a part of the IHA. For Members under 21 years of age, Contractor is responsible for ensuring that a dental screening or oral health assessment shall be performed as part of every periodic assessment by a medical Provider or coordinated with a dental Provider, with annual dental referrals made with the eruption of the child's first tooth or at 12

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months of age, whichever occurs first. Contractor shall ensure that Members are referred to appropriate Medi-Cal dental Providers. Contractor shall provide Medically Necessary Federally Required Adult Dental Services (FRADs) and fluoride varnish, dental services that may be performed by a medical professional. Dental services that are exclusively provided by dental providers are not covered under this Contract.

Contractor shall ensure the provision of covered medical services related to dental services that are not provided by dentists or dental anesthetists. Covered medical services include: laboratory services, and pre-admission physical examinations required for admission to an out-patient surgical service center or an in-patient hospitalization required for a dental procedure (including facility fees and anesthesia services for both inpatient and outpatient services). Contractor may require Prior Authorization for medical services required in support of dental procedures.

If Contractor requires Prior Authorization for these services, Contractor shall develop and publish the procedures for obtaining Prior Authorization to ensure that services for the Member are not delayed. Contractor shall submit such procedures to DHCS for review and approval.

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

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

The following groups of individuals are at risk for non-compliance for the treatment of TB: Members with demonstrated multiple drug resistance (defined as resistance to Isoniazid and Rifampin); Members whose treatment has failed or who have relapsed after completing a prior regimen; children and adolescents; and, individuals who have demonstrated noncompliance (those who failed to keep office appointments). Contractor shall refer Members with active TB and who have any of these risks to the TB Control Officer of the LHD for DOT.

Contractor shall assess the following groups of Members for potential noncompliance and for consideration for DOT: substance users, persons with mental illness, the elderly, persons with unmet housing needs, and persons with language and/or cultural barriers. If, in the opinion of Network Provider, a Member with one (1) or more of these risk factors is at risk for noncompliance, the Member shall be referred to the LHD for DOT.

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

- B. Contractor shall execute a MOU with the LHD as stipulated in Exhibit A,

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Attachment 12, Provision 2, for the provision of DOT.

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

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

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

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

15. Immunization Registry Reporting

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

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

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

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

17. Home and Community-Based Services Programs

- A. DHCS administers, either directly or through another State entity, a

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number of Medi-Cal HCBS Programs authorized under the Medi-Cal program. HCBS Programs provide long-term, community-based services and supports to Eligible Beneficiaries in the community setting of their choice instead of in an institution.

- B. Contractor shall continue to provide all services covered under this Contract to a Member when that Member is enrolled in, or applying to enroll in, receiving, or applying to receive a HCBS Program other than this Contract. Contractor shall continuously collaborate and exchange Member healthcare and medical information with all third-party entities providing the Member with Medi-Cal HCBS or administering a Medi-Cal-funded HCBS Program pursuant to the third-party entity's contractual or legal authority to administer Medi-Cal-funded HCBS Programs and/or provide HCBS to the Member. Such third-party entities include, but are not limited to:
- 1) DHCS;
 - 2) State departments that operate or administer Medi-Cal programs offering HCBS pursuant to legal authority and/or Inter-Agency Agreements with DHCS, including but not limited to, the California Department of Social Services; the California Department of Developmental Services, the California Department of Public Health, the California Department of Aging;
 - 3) Home & Community Based Alternatives Waiver Agencies;
 - 4) Assisted Living Waiver Care Coordination Agencies;
 - 5) Regional centers;
 - 6) Multipurpose Senior Services Program Sites;
 - 7) Medi-Cal AIDS Waiver Program Agencies;
 - 8) Counties;
 - 9) CCS County and State Programs;
 - 10) California Community Transitions Lead Organizations; and
 - 11) The Genetically Handicapped Persons Program (GHPP).
- C. Contractor shall have procedures in place to identify Members who may benefit from the Medi-Cal HCBS programs, and refer Members to the third-party entity administering the HCBS Program. HCBS Programs include, but are not limited to: HCBS Programs authorized under section

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1915(c) of the SSA, the Community First Choice California Medicaid State Plan (State Plan) option authorized under section 1915(k) of the SSA, State Plan HCBS benefits authorized under section 1915(i) of the SSA, and other State and federally-funded Medi-Cal HCBS Programs. If the Member is then authorized to receive Medi-Cal-funded HCBS Program services, they shall remain enrolled with Contractor and Contractor shall continue to provide all services and benefits covered under this Contract to the Member.

- D. Contractor's collaboration with third-party entities providing the Member with HCBS Program services or administering a HCBS Program pursuant to the third-party entity's contractual or legal authority to administer HCBS Programs and/or provide HCBS Program services to the Member, shall include, but is not limited to:
- 1) Maintaining sufficient staff assigned to coordinate with such third-party entities, assist Members in understanding and accessing HCBS program services, and to act as a central point of contact for questions, access, and care coordination concerns.
 - 2) Working in collaboration with such third-party entities' care managers and Providers to coordinate Covered Services, all HCBS program services, and any other relevant medical or supportive services. Such coordination shall include, but is not limited to, the timely exchange of information regarding the Member and their health care needs, services, and efforts to obtain and arrange for the provision of both Medi-Cal and non-Medi-Cal related assistance.
 - 3) As contracted delegates of the State, Contractor and such third-party entities are authorized to share Member information with one another, including PHI/PII in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and Exhibit G of this Contract, because both are under a contract with DHCS, are legally authorized to receive such information, and/or are responsible for administration of the Medi-Cal program, the provisions within the State's Business Associate Agreements, and for sharing this information with each other as part of their contractual responsibilities, per 45 CFR sections 164.502(a)(1)(ii), 164.502(a)(3), and 164.506(c).
 - 4) Contractor may, but is not required to, enter into Memorandums of Understanding (MOU) with such third-party entities administering HCBS Programs and/or providing HCBS Program services within their Service Area to document information sharing obligations and procedures. Contractor must not delay the sharing of information, nor care coordination based on the lack of a MOU. If Contractor

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has a question about whether it can share information with any particular jurisdictional entity, Contractor shall immediately contact their Medi-Cal managed care contract manager for support.

**Exhibit A, Attachment 12
LOCAL HEALTH DEPARTMENT COORDINATION**

1. Network Provider Agreements and Subcontractor Agreements

Contractor shall negotiate in good faith and execute a Network Provider Agreement and Subcontractor Agreement, as appropriate, for public health services listed in Paragraph A through Paragraph D below with the Local Health Department (LHD) in each county that is covered by this Contract. The Network Provider Agreement and Subcontractor Agreement shall specify: the scope and responsibilities of both parties in the provision of services to Members; billing and reimbursements; reporting responsibilities; and how services are to be coordinated between the LHD and Contractor, including exchange of medical information as necessary. The Network Provider Agreement and Subcontractor Agreement shall meet the requirements contained in Exhibit A, Attachment 6, Provision 14, regarding Network Provider Agreements and Subcontractor Agreements.

- A. Family Planning Services: as specified in Exhibit A, Attachment 8, Provision 9.
- B. STD services for the disease episode, as specified in Exhibit A, Attachment 8, Provision 10, by DHCS, for each STD, including diagnosis and treatment of the following STDs: syphilis, gonorrhea, chlamydia, herpes simplex, chancroid, trichomoniasis, human papilloma virus, non-gonococcal urethritis, lymphogranuloma venereum and granuloma inguinale.
- C. HIV Testing and Counseling as specified in Exhibit A, Attachment 8, Provision 11.
- D. Immunizations as specified in Exhibit A, Attachment 8, Provision 12.

To the extent that Contractor does not meet this requirement on or before four (4) months after the effective date of this Contract, Contractor shall submit documentation substantiating reasonable efforts to enter into Network Provider Agreements and Subcontractor Agreements, as appropriate.

2. Network Provider Agreements, Subcontractor Agreements or Memoranda of Understanding

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

- A. California Children Services (CCS)
- B. Maternal and Child Health (MCH)

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- C. Child Health and Disability Prevention (CHDP) Program
- D. Tuberculosis Direct Observed Therapy
- E. Women, Infants, and Children (WIC) Supplemental Nutrition Program
- F. Regional Centers for services for persons with developmental disabilities.
- G. Local Governmental Agencies for Targeted Case Management services.
- H. County department for alcohol and substance use disorder treatment services.
- I. The county In-Home Support Services (IHSS) office and IHSS Public Authority.
- J. Multipurpose Senior Service Program (MSSP)

3. County Mental Health Plan Coordination

- A. Contractor shall negotiate in good faith and execute a MOU with the county mental health plan (MHP) in accordance with W&I Code section 14715. The MOU shall specify, consistent with this Contract, the respective responsibilities of Contractor and the MHP in delivering Medically Necessary Covered Services and Specialty Mental Health Services to Members. The MOU shall address:
 - 1) Protocols and procedures for referrals between Contractor and the MHP;
 - 2) Protocols for the delivery of Specialty Mental Health Services, including the MHP's provision of clinical consultation to Contractor for Members being treated by Contractor for mental illness;
 - 3) Protocols for the delivery of mental health services within the Primary Care Provider's and mental health care Providers scope of practice;
 - 4) Protocols and procedures for the exchange of medical records information, including procedures for maintaining the confidentiality of medical records;
 - 5) Procedures for the delivery of Medically Necessary Covered Services to Members who require Specialty Mental Health Services, including:
 - a) Pharmaceutical services and Physician administered drugs billed on a medical and/or institutional claim when administered in an outpatient setting and not otherwise

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LOCAL HEALTH DEPARTMENT COORDINATION**

excluded under this Contract;

- b) Laboratory, radiological and radioisotope services;
 - c) Emergency room facility charges and professional services;
 - d) Emergency Medical Transportation and NEMT;
 - e) Home health services;
 - f) Medically Necessary Covered Services to Members who are patients in psychiatric inpatient hospitals.
- 6) Procedures for transfers between inpatient psychiatric services and inpatient medical services to address changes in a Member's medical or mental health condition;
 - 7) Procedures to resolve disputes between Contractor and the MHP.

4. MOU Approval

Any MOU that Contractor enters into with the county IHSS office and IHSS Public Authority shall be submitted to DHCS for prior approval at least 60 calendar days prior to the effective date of the MOU. DHCS shall acknowledge in writing the receipt of any material sent to DHCS by Contractor for approval within five (5) Working Days of receipt.

- A. These MOUs shall not become effective until written approval is provided by DHCS and the California Department of Social Services (CDSS) or by operation of law where DHCS has acknowledged receipt of the proposed MOU, and has neither approved nor rejected the proposed MOU within 60 calendar days of receipt.
- B. Any new or updated MOU that makes a material change to the MOU must be re-submitted to DHCS. Previous MOU approval shall be valid only until such time as the new or amended MOU is approved by DHCS and CDSS.

5. Any MOU that Contractor enters into with MSSP Provider(s) shall be submitted to DHCS for prior approval at least 60 calendar days prior to the effective date of the MOU. DHCS shall acknowledge in writing the receipt of any material sent to DHCS by Contractor for approval within five (5) Working Days of receipt.

- A. These MOUs shall not become effective until written approval is provided by DHCS and the California Department of Aging (CDA) or by operation of law where DHCS has acknowledged receipt of the proposed MOU, and has neither approved nor rejected the proposed MOU within 60 calendar days of receipt.
- B. Any new or updated MOU that makes a material change to the MOU must be

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LOCAL HEALTH DEPARTMENT COORDINATION**

re-submitted to DHCS. Previous MOU approval shall be valid only until such time as the new or amended MOU is approved by DHCS and CDA.

- C. Contractor's MOUs with MSSP sites shall include provisions for data sharing while following HIPAA regulations for health care operations. At a minimum, MOU data sharing requirements shall include:
- 1) MSSP sites sharing initial health and psychosocial assessments;
 - 2) MSSP sites sharing initial level of care determinations;
 - 3) MSSP sites sharing initial care plan;
 - 4) MSSP sites sharing any re-assessments;
 - 5) MSSP sites notifying Contractor of Member terminating from MSSP;
 - 6) Contractor sharing current durable medical equipment authorizations;
 - 7) Contractor sharing hospitalization information;
 - 8) Contractor sharing medication list; and
 - 9) Contractor sharing health risk assessment.

6. MOU Monthly Reports

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

**Exhibit A, Attachment 13
MEMBER SERVICES**

1. Members Rights and Responsibilities

A. Member Rights and Responsibilities

Contractor shall develop, implement, and maintain written policies that address the Member's rights and responsibilities and shall communicate these to its Members, Providers, Subcontractors, and, upon request, Potential Enrollees.

- 1) Contractor's written policies regarding Member rights shall include the following:
 - a) To be treated with respect, giving due consideration to the Member's right to privacy and the need to maintain confidentiality of the Member's medical information.
 - b) To be provided with information about the organization and its services.
 - c) To be able to choose a Primary Care Provider within the Contractor's Network.
 - d) To participate in decision making regarding their own health care, including the right to refuse treatment.
 - e) To voice Grievances, either verbally or in writing, about the organization or the care received.
 - f) To receive oral interpretation services for their language.
 - g) To formulate advance directives.
 - h) To have access to family planning services, Federally Qualified Health Centers, American Indian Health Service Programs, sexually transmitted disease services and emergency services outside the Contractor's Network pursuant to the federal law.
 - i) To request a State Medi-Cal fair hearing, including information on the circumstances under which an expedited fair hearing is possible.
 - j) To have access to, and where legally appropriate, receive copies of, amend or correct their Medical Record.
 - k) To change Medi-Cal Managed Care Health Plans upon request, if applicable.

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- l) To access Minor Consent Services.
 - m) To receive written Member informing materials in alternative formats, including Braille, large size print, and audio format upon request and in accordance with W & I Code Section 14182 (b)(12).
 - n) To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
 - o) To receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand.
 - p) To receive a copy of his or her Medical Records, and request that they be amended or corrected, as specified in 45 CFR sections 164.524 and 164.526.
 - q) Freedom to exercise these rights without adversely affecting how they are treated by Contractor, Network Providers, Subcontractors, or the State.
 - r) To file a request for an Appeal of an action within 60 days of the date on a NOA.
- 2) Contractor's written policy regarding Member responsibilities shall include providing accurate information to the professional staff, following instructions, and cooperating with Network Providers and Subcontractors.

B. Members' Right to Confidentiality

Contractor shall implement and maintain policies and procedures to ensure the Members' right to confidentiality of medical information.

- 1) Contractor shall ensure that Facilities implement and maintain procedures that guard against disclosure of confidential information to unauthorized persons inside and outside the Network.
- 2) Contractor shall counsel Members on their right to confidentiality and Contractor shall obtain Member's consent prior to release of confidential information, unless such consent is not required pursuant to Title 22 CCR Section 51009.

C. Members' Rights to Advance Directives

Contractor shall implement and maintain written policies and procedures

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MEMBER SERVICES**

respecting advance directives in accordance with the requirements of 42 CFR 422.128 and 42 CFR 438.3(j).

D. Interoperability Requirements for Member Records

Contractor must implement and maintain a Patient Access Application Programming Interface (API) as specified in 42 CFR section 431.60 as if such requirements applied directly to Contractor, and as set forth in APL 22-026. The Patient Access API must also meet the technical standards in 45 CFR section 170.215. Data maintained on or after January 1, 2016, must be made available to facilitate the creation and maintenance of a Member's cumulative health record.

- 1) At a minimum, Contractor must permit third-party applications to retrieve, with the approval and at the direction of the Member, the following Member records:
 - a) Adjudicated claims data from Contractor, and from any Subcontractors and Network Providers, including claims data and cost data that may be appealed, or are in the process of appeal, Provider remittances, and Member cost-sharing pertaining to such claims, within (1) Working Day after a claim is processed;
 - b) Encounter Data, including Encounter Data from any capitated Subcontractors and Network Providers, within one (1) Working Day after receiving the data from Providers;
 - c) Clinical data, including diagnoses and related codes, and laboratory test results, within one (1) Working Day after the data is received by the Contractor; and
 - d) Information about coverage for drugs administered in an outpatient setting as part of medical services, and updates to such information, including, if applicable, Member costs and any preferred drug list information, within one (1) Working Day after the effective date of any such information or updates to such information.
- 2) Contractor may deny or discontinue any third-party application's connection to an API if it reasonably determines, consistent with its security risk analysis under the HIPAA Security Rule, that continued access presents an unacceptable level of risk to the security of protected health information on its systems. The determination must be made using objective verifiable criteria that are applied fairly and consistently across all applications and

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developers, including but not limited to criteria that may rely on automated monitoring and risk mitigation tools.

2. Member Services Staff

- A. Contractor shall maintain the capability to provide Member services to Medi-Cal Members or Potential Enrollees through sufficient assigned and knowledgeable staff.
- B. Contractor shall ensure Member services staff are trained on all contractually required Member or Potential Enrollee service functions including, policies, procedures, and scope of benefits of this Contract.
- C. Contractor shall ensure that Member Services staff provides necessary support to Members with chronic conditions (such as asthma, diabetes, congestive heart failure) and disabilities, including assisting Members with Grievance and Appeal resolution, access barriers, and disability issues and referral to appropriate clinical services staff.
- D. Contractor shall ensure that Member Services staff will refer Potential Enrollees to the DHCS enrollment broker, Health Care Options (HCO) when Potential Enrollees make a request for enrollment with Contractor.

3. Written Member Information

- A. Contractor shall provide all new Medi-Cal Members, and Potential Enrollees upon request only, with Member information as specified in Title 22 CCR Section 53895 and as stated in this Provision. Compliance with items required by Section 53895(b) may be met through distribution of the Member Services Guide.

The Member Services Guide shall meet the requirements of an enrollee handbook in 42 CFR 438.10(g), and an Evidence of Coverage and Disclosure Form (EOC/DF) as stipulated by Title 28, CCR, Sections 1300.51(d), Exhibit T (EOC) or U (Combined EOC/DF) and Title 22 CCR Section 53881. In addition, the Member Services Guide shall meet the requirements contained in 42 CFR 438.10(d), and Health and Safety Code, Section 1363, as to print size, readability, and understandability of text.

- B. Contractor shall provide the Member information no later than seven (7) calendar days after the effective date of the Member's enrollment. Contractor shall revise this information, if necessary, and distribute it annually to each Member or family unit. To provide Member information in any format other than as printed materials, including but not limited to in electronic format or upon request, Contractor must submit their process to DHCS for review and approval before implementing.

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- C. Contractor shall ensure that all Member information is provided to Members at a sixth grade reading level or as determined appropriate through Contractor's PNA and approved by DHCS. Member information shall ensure Members' understanding of Contractor's processes and the Member's ability to make informed health decisions.
- D. Member information shall include the Member Services Guide/Evidence of Coverage (EOC), provider directory, significant mailings and notices, and any notices related to Grievances, actions, and Appeals. All Member information shall be in a format that is easily understood and in a font size no smaller than 12-point, pursuant to 42 CFR 438.10, 42 CFR 438.404 and 438.408, W&I Code Section 14029.91, and Title 22 CCR Section 53876.
- 1) Member information shall be translated into the identified threshold and concentration languages discussed in Exhibit A, Attachment 9, Provision 13, Linguistic Services.
 - 2) For Members with disabilities, including visual impairment Contractor shall provide Member information in alternative formats as specified by DHCS and in APL 21-004 and APL 22-002 (including Braille, large-size print font no smaller than 20-point, accessible electronic format, audio CD format, or data CD format) and through Auxiliary Aids at no cost, upon request, and in a timely fashion appropriate for the format being requested and taking into consideration the special needs of Members with disabilities or LEP.
 - a) Contractor shall inform Members who exhibit or mention difficulty reading print communications of their right to receive Auxiliary Aids and services, including alternative formats.
 - b) For Members who request an electronic alternative format to receive Member information, Contractor must inform the Member that, unless they request a password-protected format, the Member information will be provided in an electronic format that is not password protected, which may make the information more vulnerable to loss or misuse. Contractor must clearly communicate to Members that they may request an encrypted electronic format with unencrypted instructions on how the Member can access the encrypted information.
 - c) Contractor shall accommodate the communication needs of qualified individuals with disabilities, such as the Member's

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authorized representative or someone with whom it is appropriate for Contractor to communicate, such as a Member's disabled spouse. For these qualified individuals, Contractor shall be prepared to facilitate alternative format requests as identified in this Paragraph, as well as requests for other Auxiliary Aids and services.

- 3) Contractor shall establish policies and procedures to enable Members to make a standing request to receive all Member information in a specified threshold language or alternative format.
- 4) Contractor shall post a DHCS-approved nondiscrimination notice. Contractor shall also post a notice with language taglines in a conspicuously visible font size in English, at least the top 15 non-English languages in the State, and any other languages as determined by DHCS, explaining the availability of free language assistance services, including written translation and oral interpretation, and information on how to request Auxiliary Aids and services, including materials in alternative formats. The nondiscrimination notice and the notice with taglines shall include Contractor's toll-free and the TTY/TDD telephone number for obtaining these services, and shall be posted as follows:
 - a) In a conspicuous place in all physical locations where Contractor interacts with the public;
 - b) In a location on Contractor's website that is accessible on Contractor's home page, and in a manner that allows Members, Potential Enrollees, and members of the public to easily locate the information; and
 - c) In the Member Services Guide/Evidence of Coverage, and in all Member information, informational notices, and materials critical to obtaining services targeted to Members, Potential Enrollees, applicants, and members of the public, in accordance with APL 21-004, APL 22-002, 42 CFR section 438.10(d)(2)-(3), and W&I Code Section 14029.91(f).
- 5) Contractor's nondiscrimination notice shall include all information required by W&I Code Section 14029.91(e), any additional information required by DHCS, and shall provide information on how to file a discrimination Grievance with:
 - a) Both Contractor and the DHCS Office of Civil Rights, if there is a concern of discrimination based on sex, race, color, religion, ancestry, national origin, ethnic group identification,

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age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, or identification with any other persons or groups defined in Penal Code 422.56.

- b) The United States Department of Health and Human Services Office for Civil Rights if there is a concern of discrimination based on race, color, national origin, sex, age, or disability per W&I Code Section 14029.91(e).

E. Provider Directory

- 1) Contractor shall furnish its Medi-Cal provider directory to all Members and make available to DHCS for distribution as needed.
- 2) Contractor's provider directory shall be made available in both a paper and electronic form. Provider directory information shall be included with Contractor's written Member information for new Members, and thereafter available upon request. Electronic provider directories shall be posted on Contractor's web site in a machine readable file and format.
- 3) Contractor shall submit a complete provider directory to DHCS for review and approval prior to initial operations.
- 4) Contractor shall update its paper and electronic provider directories in accordance with 42 CFR 438.10(h)(3) and submit updated complete directories to DHCS as File and Use. DHCS may ask for changes at any time.
- 5) Contractor's provider directory is reviewed every six (6) months by DHCS. Findings shall be addressed immediately by Contractor.
- 6) Contractor must implement and maintain a publicly accessible standards-based provider directory API, as described in 42 CFR section 431.70 and APL 22-026, which must include the information in this Paragraph E, Provider Directory. The provider directory APIs must meet the technical standards in 45 CFR section 170.215, excluding the security protocols related to user authentication and authorization.
- 7) Provider directories shall be compliant with 42 CFR section 438.10(h) and Health and Safety Code section 1367.27, and shall include the following information for PCPs, Specialists, hospitals, behavioral health Providers, MLTSS Providers as appropriate, and any other Providers contracted for Medi-Cal Covered Services, as well as ECM Providers, and Community Supports Providers:

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- a) The provider or site's name and any group affiliation, NPI number, street address(es), all telephone numbers associated with the practice site, and, if applicable, web site URL for each service location, and Provider specialty as appropriate;
 - b) For a medical group/foundation or IPAs, the medical group/foundation or IPA name, NPI number, address, telephone number, and, if applicable, web site URL shall appear for each Physician Provider;
 - c) The hours and days when each service location is open, including the availability of evening or weekend hours;
 - d) The services and benefits available, including accessibility symbols approved by DHCS and whether the office/facility (exam room(s), equipment, etc.) can accommodate Members with physical disabilities;
 - e) The provider's cultural and linguistic capabilities, including whether non-English languages and American Sign Language are offered either by the provider or a skilled medical interpreter at the provider's facility, and if the provider has completed cultural competence training;
 - f) The telephone number to call after normal business hours;
 - g) Identification of providers or sites that are not available to all or new Members; and
 - h) The link to the Medi-Cal Rx Pharmacy Locator, which can be found on the dedicated Medi-Cal Rx website described in APL 22-012.
- F. Contractor shall provide each Member, or family unit, a Member Services Guide/EOC that constitutes a fair disclosure of the provisions of, and the right to obtain, available and accessible covered health care services. DHCS shall provide Contractor with a template for the Member Services Guide/EOC prior to distribution to Members. Contractor shall submit a complete Member Services Guide/EOC to DHCS for review and approval prior to implementing. Contractor shall ensure that the Member Services Guide/EOC includes the following information:
- 1) The plan name, address, toll-free telephone number(s) for Member services, Medi-Cal Rx telephone number(s) and website information, and any other Contractor staff providing services directly to Members, and Service Area covered under this Contract.

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- 2) A description of the full amount, duration, and scope of Medi-Cal Managed Care covered benefits and all available services including health education, interpretive services provided by Contractor's personnel and at service sites, and an explanation of "carve out" services and any service limitations and exclusions from coverage or charges for services. Include information and identification of services to which Contractor, or Subcontractor, or Network Provider has a moral objection to perform or support.
- 3) Procedures for accessing Covered Services, which explain that Covered Services shall be obtained through Contractor's Network Providers unless otherwise allowed under this Contract, and the process for Members selecting and changing their PCP. Include any applicable Network Provider arrangements that may restrict access.
- 4) A description of the Member identification card issued by Contractor, if applicable, and an explanation as to its use in authorizing or assisting Members to obtain services.
- 5) Procedures for selecting or requesting a change in PCP at any time; any requirements that a Member would have to change PCP; reasons for which a request for a specific PCP may be denied; and reasons why a Provider may request a change.
- 6) The purpose and value of scheduling an IHA appointment.
- 7) The appropriate use of health care services in a managed care system.
- 8) The availability and procedures for obtaining after hours services (24-hour basis) and care, including the appropriate Network Provider locations and telephone numbers. This shall include an explanation of the Members' right to interpreter services, at no cost, to assist in receiving after hours services.
- 9) Definition of what constitutes an emergency medical condition, emergency health care and post-stabilization services, in accordance with 42 CFR 438.10(g)(2)(v), and that Prior Authorization is not required to receive emergency services. Include the use of 911 for obtaining emergency services.
- 10) The right to receive emergency health care in any hospital or other setting, including at least a 72-hour supply of Medically Necessary medication in an emergency situation. Also include procedures for obtaining emergency health care from specified Network Providers or from Out-of-Network Providers, including outside of Contractor's

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Service Area.

- 11) Process for referral to Specialists in sufficient detail so the Member can understand how the process works, including timeframes and alternative access standards as required by W&I Code Section 14197.04 and APL 21-006.
- 12) Procedures for obtaining any transportation services to service sites that are offered by Contractor or available through the Medi-Cal program, and how to obtain such services. Include a description of both medical transportation and NMT services and the conditions under which transportation is available.
- 13) The right, and procedures, to file a Grievance and request an Appeal with Contractor, either orally, in writing, or over the phone, including procedures to Appeal decisions that deny, delay or modify a Member's request for services. Include the toll-free telephone number a Member can use to file a Grievance or request an Appeal, and the title, address, and telephone number of the person responsible for processing and resolving Grievances and Appeals and providing assistance completing the request. Information regarding the process shall include the requirements for timeframes to file a Grievance or request an Appeal, notification that an oral request for an Appeal of an action should be followed by a written request for an Appeal, and timelines for Contractor to acknowledge receipt of Grievances and Appeals, to resolve Grievances and Appeals, and to notify the Member of the resolution of Grievances or Appeals. Contractor shall inform the Member that services previously authorized by Contractor will continue while the Appeal is being resolved.
- 14) The causes for which a Member shall lose entitlement to receive services under this Contract as stipulated in Exhibit A, Attachment 16, Provision 3, Disenrollment.
- 15) Procedures for disenrollment, including an explanation of the Member's right to disenroll at any time, and reenroll in the competing plan in the county (in counties where another Medi-Cal Managed Care Health Plan is available), subject to the requirements in 22 CCR 53891(c) and any restricted disenrollment period.
- 16) Information on the Member's right to the Medi-Cal State Hearing process, the method for obtaining a State Hearing, the timeframe to request a State Hearing, and the rules that govern representation in a State Hearing. Include information on the circumstances under which an expedited State Hearing is possible and information

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regarding assistance in completing the request pursuant to 22 CCR section 53452, when a health care service requested by the Member or Provider has been denied, deferred or modified. Information on State Hearings shall also include information on the timelines which govern a Member's right to a State Hearing, pursuant to W&I Code section 10951 and the State of California Department of Social Services' Public Inquiry and Response Unit toll-free telephone number (1-800-952-5253) to request a State Hearing. Information shall include that services previously authorized by Contractor will continue while the State Hearing is being resolved if the Member requests a State Hearing in the specified timeframe.

- 17) Information on the availability of, and procedures for obtaining, services at FQHCs and American Indian Health Service Programs.
- 18) Information on the Member's right to seek family planning services from any qualified Provider of family planning services under the Medi-Cal program, including Providers outside Contractor's Provider Network, how to access these services, that a referral is not necessary, and a description of the limitations on the services that Members may seek outside the plan. Contractor may use the following statement:

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

- 19) Procedures for providing female Members with direct access to a women's health Specialist within the Network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the Member's designated source of primary care if that source is not a woman's health Specialist.
- 20) The Department of Social Services (DSS) Office of Family Planning toll-free telephone number (1-800-942-1054) providing consultation and referral to family planning clinics.

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- 21) Information on the availability of, and procedures for obtaining, Certified Nurse Midwife and Certified Nurse Practitioner services, pursuant to Exhibit A, Attachment 9, Provision 7. Nurse Midwife and Nurse Practitioner Services.
- 22) Information on the availability of transitional Medi-Cal eligibility and how the Member may apply for this program. Contractor shall include this information with all Member Service Guides sent to Members after the date such information is furnished to Contractor by DHCS.
- 23) Information on how to access State resources for investigation and resolution of Member complaints, including a description of the DHCS Medi-Cal Managed Care Ombudsman Program and toll-free telephone number (1-888-452-8609), and the DMHC, Health Maintenance Organization (HMO) Consumer Service toll-free telephone number (1-800-400-0815).
- 24) Information concerning the provision and availability of services covered under the CCS program from Out-of-Network Providers and how to access these services.
- 25) An explanation of the expedited disenrollment process for Members qualifying under conditions specified under 22 CCR section 53889(j), which includes children receiving services under the Foster Care or Adoption Assistance Programs; Members with special health care needs, and Members already enrolled in another Medi-Cal, Medicare or commercial managed care plan.
- 26) Information on how to obtain Minor Consent Services through Contractor's Provider Network, an explanation of those services, and information on how they can also be obtained out of the Contractor's Provider Network.
- 27) An explanation on how to use the FFS system when Medi-Cal Covered Services are excluded or limited under this Contract and how to obtain additional information.
- 28) An explanation of an American Indian Member's right to not enroll in a Medi-Cal Managed Care plan, to be able to access American Indian Health Service Programs, to choose an American Indian Health Care Provider within Contractor's Network as a Primary Care Provider, and to disenroll from Contractor's plan at any time, without cause.
- 29) A notice regarding the positive benefits of organ donations and how a Member can become an organ or tissue donor. Pursuant to

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California Health and Safety Code Section 7158.2, this notice must be provided upon enrollment and annually thereafter in the evidence of coverage (Member Services Guide), health plan newsletter or any other direct communication with Members.

- 30) A statement as to whether the Contractor uses financial bonuses or other incentives to its Network Providers and that the Member may request additional information about these bonuses or incentives from the plan, the Member's Network Provider, or the Network Provider's medical group or independent practice association, pursuant to California Health and Safety Code, Section 1367.10.
- 31) Policies and procedures regarding a Members' right to formulate advance directives. This information shall include the Member's right to be informed by Contractor of State law regarding advance directives, and to receive information from Contractor regarding any changes to that law. The information shall reflect changes in State law regarding advance directives as soon as possible, but no later than 90 calendar days after the effective date of change.
- 32) Instructions on how a Member can view online, or request a copy of, Contractor's non-proprietary clinical and administrative policies and procedures.
- 33) That oral interpreter services are available for any language spoken by the Member, and written translations of Member materials are available in the identified threshold languages, both free of charge, with instruction on how to access these services.
- 34) That Auxiliary Aids and services are available upon request and at no cost for Members with disabilities, and how to access these services.
- 35) Information on how to report suspected fraud or abuse.
- 36) Any other information determined by DHCS to be essential for the proper receipt of Covered Services.

G. Member Identification Card

Contractor shall provide an identification card to each Member, which identifies the Member and authorizes the provision of Covered Services to the Member. The card shall specify that emergency services rendered to the Member by non-contracting Providers are reimbursable by the Contractor without prior authorization.

4. Notification of Changes in Access to Covered Services

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- A. Contractor shall ensure Medi-Cal Members are notified in writing of any changes in the availability or location of Covered Services, or any other changes in information listed in 42 CFR Section 438.10(g), at least 30 calendar days prior to the effective date of such changes. In the event of an emergency or other unforeseeable circumstances, Contractor shall provide notice of the emergency or other unforeseeable circumstance to DHCS as soon as possible. The notification must be presented to and approved in writing by DHCS prior to its release.
- B. Contractor is required to provide written notice to all impacted Members informing them of a termination of a Network Provider or Subcontractor either 30 calendar days prior to the effective date of the contract termination or 15 calendar days after receipt or issuance of the termination notice, whichever is later, unless directed by DHCS. If Contractor is notified of a contract termination less than 30 days prior to the effective date of the termination, Contractor must immediately notify all impacted Members of the termination.

5. Primary Care Provider Selection

- A. Contractor shall implement and maintain DHCS-approved procedures to ensure that each new Member who is not enrolled in comprehensive Other Health Coverage (OHC) has an appropriate and available PCP.
 - 1) Comprehensive OHC refers to:
 - a) Members with the OHC Code indicator C, H, F, K, or P as listed in the 834 file, or,
 - b) OHC with a scope of coverage of at least Outpatient, Inpatient, and Medical/Allied (OIM) Services found in positions 119 through 126 in the Health Insurance System Database (HISDB) file.
 - 2) Contractor shall provide each new Member an opportunity to select a PCP within the first 30 calendar days of enrollment.
 - 3) Contractor may allow Members to select a clinic that provides Primary Care services for a PCP.
 - 4) If Contractor's Network includes Nurse Practitioners, Certified Nurse Midwives, or Physician Assistants, the Member may select a Nurse Practitioner, Certified Nurse Midwife, or Physician Assistant within 30 calendar days of enrollment to provide Primary Care services in accordance with 22 CCR section 53853(a)(4).
 - 5) Contractor shall provide a mechanism for SPD beneficiaries to

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select a Specialist or clinic that meets DHCS Network Provider Agreement requirements as stated in Attachment 6 of this Contract as a PCP if the Specialist or clinic agrees to serve as a Primary Care Provider and is qualified to treat the required range of conditions of the SPD beneficiary, per W&I Code section 14182 (b)(11).

- 6) Contractor shall ensure that Members are allowed to change a PCP, Nurse Practitioner, Certified Nurse Midwife or Physician Assistant, upon request, by selecting a different Primary Care Provider from Contractor's Network.
- B. Members who transition out of comprehensive OHC must have an appropriate and available PCP assigned by Contractor within 30 days of the OHC change notification.
- C. Contractor shall disclose to affected Members any reasons for which their selection or change in PCP could not be made.
- D. Contractor shall ensure that Members with an established relationship with a Network Provider, who have expressed a desire to continue their patient/Network Provider relationship, are assigned to that Network Provider without disruption in their care.
- E. Contractor shall ensure that Members may choose Traditional and Safety-Net Providers as their Primary Care Provider, and that American Indian Members may choose an American Indian Health Care Provider within Contractor's Network as their Primary Care Provider.
- F. Contractor shall not be obligated to require Full Benefit Dual Eligible Members to select a Medi-Cal Primary Care Provider. Nothing in this section shall be construed to require Contractor to pay for services that would otherwise be paid for by Medicare.

6. Primary Care Provider Assignment

- A. If the Member does not select a Primary Care Provider within 30 calendar days of the effective date of enrollment, Contractor shall assign that Member to a Primary Care Provider and notify the Member and the assigned Primary Care Provider no later than 40 calendar days after the Member's enrollment. Contractor shall ensure that adverse selection does not occur during the assignment process of Members to Providers.
- B. If a Member does not select a Primary Care Provider within 30 calendar days of the effective date of enrollment, Contractor shall use utilization data or other data sources provided by DHCS, including electronic data, to establish existing Provider relationships for the purpose of Primary Care

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Provider assignment, including a Specialist or clinic for a PCP assignment for a SPD beneficiary if a preference for either has been indicated. Contractor shall comply with all federal and State privacy laws in the provision and use of this data.

- C. Contractor shall notify the Primary Care Provider that a Member has been assigned or selected to the Provider within ten (10) calendar days from when selection or assignment is completed by the Member or Contractor, respectively.
- D. Contractor shall maintain procedures that proportionately include contracting Traditional and Safety-Net Providers in the assignment process for Members who do not choose a Primary Care Provider.
- E. Contractor shall not be required to assign Members who are eligible for services through Medicare to a Medi-Cal Primary Care Provider except as specified in APL 14-015. Nothing in this section shall be construed to require health plans to pay for services that would otherwise be paid for by Medicare.
- F. Contractor shall provide any Member utilization data received from DHCS to the Primary Care Provider or Subcontractor to which a Member has been assigned to or has selected for the coordination of the Members care. To the extent the Provider is not equipped to receive the data, Contractor shall make it available to the Primary Care Provider or Subcontractor.

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

- A. Contractor shall notify Members of a decision to deny, delay, or modify requests for Prior Authorization, in accordance with 42 CFR 438.210(c) and Title 22 CCR Sections 51014.1 and 53894 by providing a NOA to Members and/or their authorized representative, regarding any denial, delay or modification of a request for approval to provide a health care service. This notification must be provided as specified in 42 CFR 438.404, Title 22 CCR Sections 51014.1, 51014.2, 53894, and Health and Safety Code Section 1367.01. Such notice shall be deposited with the United States Postal Service in time for pick-up no later than the third working day after the decision is made, not to exceed 14 calendar days from receipt of the original request. If the decision is deferred because an extension is requested or justified as explained in Exhibit A, Attachment 5, Provision 3, Contractor shall notify the Member in writing of the deferral of the decision no later than 14 calendar days from the receipt of the original request. If the final decision is to deny or modify the request, Contractor shall provide a written notification of the decision to Members no later than 28 calendar days from the receipt of the original request.

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

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

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

- 1) Death of a Member;
- 2) Member provides a written statement requesting service termination or giving information requiring termination or reduction of services;
- 3) Member admission into an institution that makes the Member ineligible for further services;
- 4) Member's address is unknown and mail directed to the Member has no forwarding address;
- 5) Member has been accepted for Medi-Cal services by another local jurisdiction;
- 6) Member's Primary Care Physician prescribes a change in the level of medical care;
- 7) An adverse determination made with regard to the preadmission screening requirements for nursing facility admissions on or after January 1, 1989; or
- 8) Safety or health of individuals in a facility would be endangered, Member's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the Members urgent medical needs, or Member has not resided in the nursing facility for a minimum of 30 days.

- C. Contractor shall provide expedited advanced notice to a Member when Contractor, Subcontractor, or Primary Care Physician indicates that the standard timeframe could seriously jeopardize the Member's life, health,

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or ability to attain, maintain, or regain maximum function. Contractor shall ensure an expedited authorization decision and provide an expedited notice as the Member's health condition requires and no later than 72 hours after receipt of the request for services. Upon approval from DHCS, Contractor may extend the 72 hour expedited period to 14 calendar days if the Member requests an extension, or if Contractor justifies a need for additional information and that the extension is in the Member's interest.

- D. Contractor shall provide for a written notification to the Member and the Member's representative on a standardized form informing the Member of all the following:
- 1) The Member's right to, and method of obtaining, a State Hearing to contest Contractor's denial, deferral, delay or modification of a requested service.
 - 2) The Member's right to represent himself/herself at the State Hearing or to be represented by legal counsel, friend or other spokesperson.
 - 3) The name and address of Contractor and the State of California Department of Social Services toll-free telephone number for obtaining information on legal service organizations for representation.

**Exhibit A, Attachment 14
MEMBER GRIEVANCE AND APPEAL SYSTEM**

1. Member Grievance and Appeal System

Contractor shall have in place a system in accordance with Title 28, CCR, Section 1300.68 and 1300.68.01, Title 22 CCR Section 53858, Exhibit A, Attachment 13, Provision 4, Paragraph F.13), and 42 CFR 438. 402-424. Contractor shall follow Grievance and Appeal requirements, and use all notice templates included in APL 21-011. Contractor shall ensure that its Grievance and Appeal system meets the following requirements:

- A. Members, or a Provider or authorized representative acting on behalf of a Member and with the Member's written consent, may file a Grievance or request an Appeal with Contractor either orally or in writing.
- B. Ensure timely written acknowledgement for each Grievance and request for an Appeal, and provide a notice of resolution to the Member as quickly as the Member's health condition requires, not to exceed 30 calendar days from the date Contractor receives the oral request for a Grievance or oral request for an Appeal. Contractor shall notify the Member a Provider, or authorized representative acting on behalf of a Member and with the Member's written consent of the resolution in a written Member notice.
- C. For Members accessing the Grievance and Appeal system, ensure that Members are given assistance when completing Grievance and Appeal forms and other procedural steps. This includes but is not limited to, providing all documents relied on for Contractor's decision to the Member, and providing Auxiliary Aids and services upon request, such as interpreter services and a toll-free number with TTY/TDD and interpreter capability.
- D. Ensure that the person making the final decision for the proposed resolution of Grievances or Appeals has neither participated in any prior decisions related to the Grievance or Appeal, nor is a subordinate of someone who has participated in a prior decision. Contractor shall ensure that the person making a decision has clinical expertise in treating a Member's condition or disease if deciding on any of the following:
 - 1) An Appeal of a denial based on lack of Medical Necessity or that the service is experimental/investigational;
 - 2) A Grievance regarding denial of an expedited resolution of an Appeal; and
 - 3) Any Grievance or Appeal involving clinical issues.
- E. Consider all comments, documents, records, and other information submitted by the Member or their representative, regardless of whether such information was submitted or considered during the initial review.

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- F. Ensure that Members are given a reasonable opportunity to present to Contractor evidence and testimony, and make legal or factual arguments, in person as well as in writing, in support of their Grievance or Appeal. Contractor shall inform Members of the limited time available to present evidence sufficiently in advance of the resolution timeframes specified in this Contract, including for expedited Appeals.
- G. Notice of resolutions for Grievances and Appeals shall be in a format and language that, at a minimum, meets the standards set forth in 42 CFR 438.10 and Exhibit A, Attachment 13, Provision 4, Paragraph D, Member Services, of this Contract. Contractor must ensure that Language Assistance Taglines and a Nondiscrimination Notice meeting the minimum requirements of provided with APL 20-015 accompanies each member notification, and that the Nondiscrimination Notice is made available, upon request or as otherwise required by law, in any of the threshold languages or in an ADA-compliant, accessible format.
- H. Provide oral notice of the resolution of an expedited Appeal within 72 hours.
- I. Provide its Grievance and Appeal system requirements to Subcontractors at the time that they enter into a Subcontractor Agreement, to Network Providers at the time that they enter into a Network Provider Agreement, and ensure that Subcontractors and Network Providers are informed of any new requirements in a timely manner.
- J. Compile the systematic aggregation and analysis of Grievance and Appeal data and use for Quality Improvement. Contractor shall continually evaluate and analyze Grievance and Appeal data to identify systemic patterns of improper service denials and other trends impacting health care delivery to Members.

2. Grievance Process

Contractor shall implement and maintain procedures as described below for Grievances and the expedited review of Grievances required under 42 CFR 438.402, 438.406, and 438.408; Title 28, CCR, Sections 1300.68 and 1300.68.01; and Title 22 CCR Section 53858.

- A. Procedure to ensure a Member may file a Grievance with Contractor at any time to express dissatisfaction about any matter other than an action resulting in a NOA.
- B. Procedure to allow Members to file a Grievance when they disagree with Contractor's decision to extend the timeframe for resolution of an Appeal or expedited Appeal.
- C. Procedure to ensure that every Grievance submitted is reported to the

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MEMBER GRIEVANCE AND APPEAL SYSTEM**

appropriate level, i.e., quality of care versus quality of service.

- D. Procedure to ensure the participation of individuals with authority to require corrective action. Grievances related to medical quality of care issues shall be referred to Contractor's medical director.
- E. Contractor shall provide written acknowledgement within five (5) calendar days of receipt of the Grievance. The acknowledgement letter shall advise the Member that the Grievance has been received, the date of the receipt, and provide the name, telephone number, and address of the representative who may be contacted about the Grievance.

3. Grievance and Appeal Log and Quarterly Grievance and Appeal Report

- A. Contractor shall accurately maintain and make accessible to DHCS, and have available for CMS upon request, Grievance and Appeal logs, including copies of Grievance and Appeal logs of any Subcontractor delegated responsibility to maintain and resolve Grievances. Grievance and Appeal logs shall include all the required information set forth in Title 22 CCR Section 53858(e).
- B. The report shall include Grievances and Appeals handled by Subcontractors. Contractor shall ensure that all documents generated or obtained by Contractor in the course of responding to Adverse Benefit Determinations, Grievances, Appeals, and Independent Medical Reviews are retained for at least 10 years pursuant to 42 CFR 438.3(u).
- C. Contractor shall submit a monthly Grievance and Appeal report for Medi-Cal Members only in the form that is required by and submitted to DMHC, as set forth in Title 28 CCR Section 1300.68(f), with additional information required by DHCS per 42 CFR 438.416 and 22 CCR section 53858(e).
 - 1) In addition to the types or nature of Grievances listed in Title 28 CCR Section 1300.68(f)(2)(D), the report shall also include, but not be limited to, timely assignments to Primary Care Providers, issues related to accommodating cultural and linguistic sensitivities, difficulty with accessing Specialists, and Grievances related to Contractor's denial of Out-of-Network requests.
 - 2) For the Medi-Cal category of the report, Contractor shall provide the following additional information on both Grievances and Appeals:
 - a) The date Contractor received the Grievance or Appeal;
 - b) A general description of the reason for the Grievance or Appeal;

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- c) The date(s) of Contractor's review of the Grievance or Appeal, or if applicable, a review meeting;
 - d) The resolution and date of resolution, at each level of the Grievance or Appeal;
 - e) The name of the Member who requested the review of a Grievance or Appeal;
 - f) The timeliness of responding to the Member; and
 - g) The geographic region, ethnicity, gender, and primary language of the Member.
- D. Contractor shall submit complete, accurate, and timely Grievance and Appeal data within ten (10) calendar days following the end of each month under this Contract or as otherwise agreed upon by DHCS, and in the format specified by DHCS and as required in Exhibit A, Attachment 3, Provision 7, Program Data. Contractor shall certify all Network data as set forth in 42 CFR section 438.606.

4. Notice of Action (NOA)

- A. A NOA is a formal letter, in a format approved by DHCS, informing a Member of any of the following actions taken by Contractor and sent within the corresponding timeframes:
- 1) For the denial, delay, modification, or limited authorization of a requested Covered Service, send within five (5) business days from receipt of the information reasonably necessary to render a decision, with a possible extension of up to 14 additional calendar days if the Member requests an extension, or if Contractor justifies to DHCS a need for additional information and how the extension is in the Member's interest.
 - 2) For the reduction, suspension, or termination of a previously authorized Covered Service, send within ten (10) calendar days advance written notice to ensure the Member has time to request continuation of the disputed service until Appeal rights have been exhausted or there is a final hearing decision on the Appeal as required by 42 CFR 438.420.
 - 3) For a denial, in whole or in part, of payment for a Covered Service, send at the time of any action affecting the claim.
 - 4) For the decision to extend the time frame to authorize a Covered Service and provide information on filing a

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Grievance if the Member disagrees with the extension, send as expeditiously as the Member's health requires but no later than within 14 calendar days following receipt of the service request.

- 5) For an expedited service authorization decision, send within 72 hours of receipt of the request.
- B. A written NOA shall be in a format and language that, at a minimum, meets the standards set forth in 42 CFR section 438.10 and Exhibit A, Attachment 13, Member Services, Provision 3, Paragraph D, and shall include all of the following:
- 1) A clear and concise explanation of the action that Contractor or its Subcontractor has taken or intends to take including where requested, a fully translated written notice, including a translated clinical rationale, within 30 calendar days. In cases where Contractor provides an initial partially translated clinical rationale in the notice, Contractor shall make an affirmative effort to reach Members by telephone to offer verbal translation of the notice and any other assistance the member may need. Contractor is required to make at least three documented attempts to reach the Member by telephone and offer language assistance including verbal translation of notice.
 - 2) The reason for the action, including notification to the Member of the right to be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and any other information Contractor or its Subcontractor relied on for the decision relevant to the action, including clinical criteria; Medical Necessity criteria, and any processes, strategies, or evidentiary standards used;
 - 3) The Member's right to request an Appeal with Contractor no later than 60 calendar days from the date on the NOA, and information on exhausting Contractor's one-level Appeal system;
 - 4) That an expedited Appeal is available if the Member's health condition requires resolution in less than 72 hours and how to request an expedited Appeal;
 - 5) The process for a Member to request a State Hearing after having exhausted Contractor's internal Appeal process, and having received notice that Contractor is upholding its action, or that a Member may request a State Hearing in cases where Contractor fails to send a Notice of Appeal Resolution (NAR) in response to the Appeal within 30 calendar days;

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- 6) The Member's right to have Covered Services continue pending the resolution of the Appeal as required by 42 CFR 438.420; and the process for the Member to request continuation of Covered Services.
 - 7) The Member's right to request a review of Contractor's action, called an Independent Medical Review (IMR), from DMHC and that the IMR must be requested before there is a decision on a State Hearing.
- C. Contractors are not permitted to make any changes to the NOA templates or NOA "Your Rights" attachment without prior review and approval from DHCS, except to insert information specific to members, as required.
- D. For visually impaired Members, the NOA must be provided in the Member's selected alternative format in order to be considered adequate notice. Contractor shall not deny, delay, modify, limit, or terminate services or treatments without providing adequate notice within the timeframes stated in Paragraph A of this Provision. In accordance with APL 22-002, Contractor shall calculate the appropriate timeframe(s) for a visually impaired Member to take action from the date of receiving adequate notice in their selected alternative format, including all deadlines for Appeals.

5. Appeal Process

Contractor shall have in place a process as required below to resolve Member requests for Appeals. Contractor may have only one (1) level of Appeal for Members. Upon request, Contractor shall assist Members in preparing their Appeal.

- A. Following the receipt of a NOA, a Member has 60 calendar days from the date on the NOA to file a request for an Appeal either orally or in writing. The Member, or a Provider or authorized representative acting on behalf of a Member and with the Member's written consent, may request an Appeal. Unless the Member is requesting an expedited Appeal, an oral request for an Appeal should be followed by a written and signed Appeal. However, Contractor shall still consider the date the Member made the oral request for an Appeal as the filing date regardless of whether the Member submitted a written request for an Appeal for purposes of resolving the Appeal within 30 days.
- B. If Contractor fails to send a Member resolution notice within 30 calendar days, or fails to comply with the notice requirements of 42 CFR section 438.10, the Member is deemed to have exhausted Contractor's internal Appeal process and may request a State Hearing. This is referred to as Deemed Exhaustion.

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MEMBER GRIEVANCE AND APPEAL SYSTEM**

- C. Contractor's NAR, at a minimum, must include the result and date of the Appeal resolution. For decisions not wholly in the Member's favor, Contractor, at a minimum, must include:
- 1) Member's right to request a State Hearing;
 - 2) How to request a State Hearing;
 - 3) Right to continue to receive benefits pending a State Hearing;
 - 4) How to request a continuation of benefits, and requirements to file a continuation request within ten (10) calendar days of when the NOA was sent, or before the intended effective date of the proposed action;
 - 5) The right to request an IMR or a review of Contractor's decision by DMHC and that the IMR must be requested before there is a final State Hearing decision; and
 - 6) The DHCS-approved "Your Rights" Attachment.
- D. Contractor may extend the timeframe to resolve an Appeal by up to 14 calendar days if the Member requests an extension or Contractor shows that there is a need for additional information. Contractor shall maintain documentation to demonstrate to the Department, why the delay is in the Member's interest. If the timeframe extension has not been requested by the Member, Contractor shall:
- 1) Make reasonable efforts to give the Member prompt oral notice of the delay.
 - 2) Give the Member a written notice of the reason to extend the timeframe within two (2) calendar days, including information on the right to file an additional Grievance for the delay.
 - 3) Resolve the Appeal as expeditiously as the Member's health condition requires and no later than the date the extension expires.
- E. Contractor must authorize or provide the disputed services promptly, and as expeditiously as the Member's health condition requires, but no later than 72 hours from the date it reverses the action, if the services are not furnished while the Appeal is pending and Contractor reverses a decision to deny, limit, or delay services.
- F. Contractor must pay for disputed services if the Member received the disputed services while the Appeal was pending.
- G. Contractor shall continue providing Covered Services while the Appeal is

**Exhibit A, Attachment 14
MEMBER GRIEVANCE AND APPEAL SYSTEM**

pending if all of the following conditions are met:

- 1) The Member filed their Appeal within the required timeframes,
- 2) The Appeal involves the termination, suspension, or reduction of previously authorized Covered Services;
- 3) The Covered Services were ordered by an authorized Provider;
- 4) The period covered by the original authorization has not expired; and
- 5) The Member files for continuing Covered Services within 10 calendar days of when the NOA was sent, or before the intended effective date of the proposed action.

H. If Contractor, at the Member's request, continues or reinstates the provision of Covered Services while an Appeal or State Hearing is pending, those services must continue until:

- 1) The Member withdraws their request for an Appeal or a State Hearing;
- 2) The Member fails to request a State Hearing and continuation of Covered Services within ten (10) calendar days of when the NOA was sent; or
- 3) The State Hearing decision is adverse to the Member.

I. The Member must be given the opportunity before and during their Appeals process to examine their case file, including medical records and any other documents and records considered during the Appeals process. Contractor shall provide, sufficiently in advance of the resolution timeframe and free of charge, the Member's case file, including medical records and any other documents and records considered during the Appeal process.

6. Responsibilities in Expedited Appeals

Contractor shall implement and maintain procedures as described below to resolve expedited Appeals. Contractor shall follow the expedited Appeal process when it determines or the requesting Provider indicates that taking the time for a standard resolution could seriously jeopardize the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

A. A Member, a Provider or an authorized representative acting on behalf of a Member and with the Member's written consent, may file an expedited Appeal either orally or in writing. No additional follow-up from the Member is required. Contractor must ensure that punitive action is not taken

**Exhibit A, Attachment 14
MEMBER GRIEVANCE AND APPEAL SYSTEM**

against a Provider who requests an expedited resolution or supports a Member's Appeal.

- B. Contractor must inform the Member of the limited time available for the Member to present evidence and allegations of fact or law, in person and in writing, sufficiently in advance of the resolution timeframe.
- C. Contractor must provide a Member notice, as quickly as the Member's health condition requires, within 72 hours from the day Contractor receives the request for an Appeal.

Contractor may extend the timeframe to resolve an expedited Appeal by up to 14 days if the Member requests an extension or if Contractor shows that there is a need for additional information and how the delay is in the Member's interest. If the extension was not requested by the Member, Contractor shall make reasonable efforts to give the Member a prompt oral notice of the delay, and within two (2) calendar days, provide the Member with written notice that includes the reason Contractor needs the extension. The notice shall include information on the right to file a Grievance if the Member disagrees Contractor's extension is appropriate. Contractor shall resolve the Appeal as expeditiously as the Member's health condition requires and no later than the date the extension expires. Contractor shall maintain documentation to demonstrate to the Department, why the extension is necessary.

- D. Contractor must make a reasonable effort to provide oral notice of expedited Appeal decision.
- E. If Contractor denies a request for an expedited resolution of an Appeal, it must process the request for an Appeal in accordance with the standard Appeal process timeframes for resolutions and extensions as required in Provision 5 of this Attachment.

7. State Hearings and Independent Medical Reviews

- A. State Hearings
 - 1) Members, or a Provider or authorized representative acting on behalf of a Member and with the Member's written consent, may request a State Hearing:
 - a) After receiving a notice of Appeal resolution confirming that Contractor's action has been upheld, and the request is made within 120 calendar days from the date on the notice Appeal of resolution;
 - b) If the Member is deemed to have exhausted the Appeals process due to Contractor's failure to comply with Appeal

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MEMBER GRIEVANCE AND APPEAL SYSTEM**

notice and timing requirements, as stated in this Contract, the Member may request a State Hearing. In such cases of deemed exhaustion, Contractor must not request a dismissal of the State Hearing based on a failure to exhaust Contractor's internal Appeal process; or

- c) If Contractor fails to provide Appeal notices required in 42 CFR section 438.408 to a Member with a visual impairment, in the Member's selected alternative format and within the applicable federal or State timeframes, the Member is deemed to have exhausted Contractor's internal Appeal process and may immediately request a State Hearing. In such cases, Contractor is prohibited from requesting dismissal of a State Hearing on the basis of failure to exhaust Contractor's internal Appeal process.
- 2) Upon request, Contractor shall assist the Member with preparing for the State Hearing and must provide the Member, upon request, with all documents, guidelines and clinical criteria Contractor relied on for its initial denial and anything Contractor considered during its internal Appeal process.
- 3) Contractor must provide its Statement of Position for the State Hearing to the Member and to the Department of Social Services (DSS) at least two (2) Working Days before the hearing.
- 4) Contractor must ensure that an employee familiar with the facts of the case and Contractor's basis for upholding its Adverse Benefit Determination is available to participate in the State Hearing. Contractor must ensure that it provides accurate contact information for Contractor's representative to ensure appearance at the State Hearing via telephone or in person.
- 5) In cases where the State Hearing decision overturns Contractor's decision, Contractor must authorize or provide the disputed services promptly, and as expeditiously as the Member's health condition requires, but no later than 72 hours from the date Contractor receives notice that the State Hearing decision reversed Contractor's decision.
- 6) Contractor must pay for disputed services if the Member received the disputed services while the State Hearing was pending.

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- 7) The parties to a State Hearing must include Contractor as well as the Member and their representative or the representative of a deceased Member's estate.
- 8) Contractor shall notify Members that the State must reach its decision for a standard State Hearing within 90 days of the date of the request. For an expedited State Hearing, the State must reach its decision within 72 hours of receipt of the expedited State Hearing request. Contractor shall also comply with all other requirements as required by 42 CFR section 438.410, W&I Code section 10951.5, and as outlined in APL 21-001.

B. Expedited State Hearings

- 1) Within two (2) Working Days of being notified by DHCS or DSS that a Member has filed a request for State Hearing which meets the criteria for expedited resolution, Contractor shall deliver directly to the designated/appropriate DSS administrative law judge all information and documents which either support, or which Contractor considered in connection with, the action which is the subject of the expedited State Hearing. This includes, but is not necessarily limited to, copies of the relevant treatment authorization request and NOA, plus any pertinent Appeal resolution notice and all documents Contractor relied on for its denial, including clinical criteria and guidelines. If the NOAs or NARs are not in English, fully translated copies shall be transmitted to CDSS along with copies of the original NOAs and NARs.
- 2) One (1) or more of Contractor's representatives with knowledge of the Member's condition and the reason(s) for the action, which is the subject of the expedited State Hearing, shall be available by phone during the scheduled State Hearing.

C. Independent Medical Review (IMR)

- 1) Members have the right to request an IMR of an action resulting in a Member request for an Appeal, or the outcome of an Appeal.
- 2) For a Member to obtain an independent medical review, they must request it. Contractor shall not require a Member to request an IMR before, or use one as a deterrent to, requesting a State Hearing.
- 3) IMRs shall be conducted by DMHC independently from either the Member or Contractor, and at no cost to the Member.
- 4) IMRs shall not extend any of the time frames stated in this Contract for Appeals, and shall not disrupt the continuation of Covered

**Exhibit A, Attachment 14
MEMBER GRIEVANCE AND APPEAL SYSTEM**

Services per 42 CFR 438.420.

8. Continuation of Services Until Appeal and State Hearing Rights Are Exhausted

- A. Contractor shall automatically continue providing Covered Services while the Appeal and State Hearing are pending if all of the following conditions are met:
- 1) The Member filed their Appeal within the required timeframes set forth in 42 CFR 438.420,
 - 2) The Appeal involves the termination, suspension, or reduction of previously authorized Covered Services;
 - 3) The Covered Services were ordered by an authorized Provider;
 - 4) The period covered by the original authorization has not expired; and
 - 5) The Member files for continuing Covered Services within 10 calendar days of when the NOA was sent, or before the intended effective date of the proposed adverse benefit determination.
- B. If Contractor, at the Member's request, continues or reinstates the provision of Covered Services while an Appeal or State Hearing is pending, those services must continue until:
- 1) The Member withdraws their request for an Appeal or a State Hearing;
 - 2) The Member fails to request a State Hearing and continuation of Covered Services within ten (10) calendar days of when the NOA was sent; or
 - 3) The final State Hearing decision is adverse to the Member.
- C. Contractor must pay for disputed services, until there is a final decision on the State Hearing, if the Member received the disputed services while the Appeal or State Hearing was pending.

9. Discrimination Grievances

Contractor shall process a Grievance for discrimination as required by federal and State nondiscrimination law stated in 45 CFR Section 84.7; 34 CFR Section

**Exhibit A, Attachment 14
MEMBER GRIEVANCE AND APPEAL SYSTEM**

106.8; 28 CFR Section 35.107; and W&I Code Section 14029.91(e)(4).

- A. Contractor shall designate a discrimination Grievance coordinator responsible for ensuring compliance with federal and State nondiscrimination requirements, and investigating discrimination Grievances related to any action that would be prohibited by, or out of compliance with, federal or State nondiscrimination law.
- B. Contractor shall adopt procedures to ensure the prompt and equitable resolution of discrimination Grievances by Contractor. Contractor shall not require a Member or Potential Enrollee to file a discrimination Grievance with Contractor before filing with the DHCS Office of Civil Rights or the U.S. Health and Human Services Office for Civil Rights.
- C. Within ten (10) calendar days of mailing a discrimination Grievance resolution letter, Contractor shall submit the following information regarding the discrimination Grievance in a secure format to the DHCS Office of Civil Rights:
 - 1) The original discrimination Grievance;
 - 2) The Provider's or other accused party's response to the discrimination Grievance;
 - 3) Contact information for the personnel primarily responsible for investigating and responding to the discrimination Grievance on behalf of Contractor;
 - 4) Contact information for the person filing the discrimination Grievance, and for the Provider or other accused party that is the subject of the discrimination Grievance;
 - 5) All correspondence with the person filing the discrimination Grievance regarding the discrimination Grievance, including, but not limited to, the discrimination Grievance acknowledgment letter and resolution letter; and
 - 6) The results of Contractor's investigation, copies of any corrective action taken, and any other information that is relevant to the allegation(s) of discrimination.

**Exhibit A, Attachment 15
MARKETING**

1. Training and Certification of Marketing Representatives

If Contractor conducts Marketing, Contractor shall develop a training and certification program for Marketing Representatives and ensure that all staff performing Marketing activities or distributing Marketing material are appropriately certified.

A. Contractor is responsible for all Marketing activity conducted on behalf of the Contractor. Contractor will be held liable for any and all violations by any Marketing Representatives. Marketing staff may not provide Marketing services for more than one Contractor. Marketing Representatives shall not engage in marketing practices that discriminate against an Eligible Beneficiary or Potential Enrollee because of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56.

B. Training Program

Contractor shall develop a training program that will train staff and prepare Marketing Representatives for certification. Contractor shall develop a staff orientation and Marketing representative's training/certification manual. The manual shall, at a minimum, cover the following topics:

- 1) An explanation of the Medi-Cal Program, including both FFS and capitated contractors, and eligibility.
- 2) Scope of Services
- 3) An explanation of the Contractor's administrative operations and health delivery system program, including the Service Area covered, Excluded Services, additional services, conditions of enrollment and aid categories.
- 4) An explanation of Utilization Management (how the beneficiary is obligated to obtain all non-emergency medical care through the Contractor's Provider Network and describing all precedents to receipt of care like referrals, Prior Authorizations, etc.).
- 5) An explanation of the Contractor's Grievance and Appeal procedures.
- 6) An explanation of how a beneficiary disenrolls from the Contractor and conditions for both voluntary and mandatory disenrollment reasons.
- 7) An explanation of the requirements of confidentiality of any

**Exhibit A, Attachment 15
MARKETING**

information obtained from Medi-Cal beneficiaries including information regarding eligibility under any public welfare or social services program.

- 8) An explanation of how Marketing Representatives will be supervised and monitored to assure compliance with regulations.
- 9) An explanation of acceptable communication and sales techniques. This shall include an explanation of prohibited Marketing Representative activities and conduct.
- 10) An explanation that discrimination in enrollment and failure to enroll a beneficiary due to a pre-existing medical condition (except for conditions requiring Excluded Services) are illegal.
- 11) An explanation of the consequences of misrepresentation and Marketing abuses (i.e., discipline, suspension of Marketing, termination, civil and criminal prosecution, etc.). The Marketing Representative must understand that any abuse of Marketing requirements can also cause the termination of the Contractor's contract with the State.

2. DHCS Approval

- A. Contractor shall not conduct Marketing activities presented in Provision 3, Paragraph A, Subparagraph 2), item d) below, without written approval of its Marketing plan, or changes to its Marketing plan, from DHCS. In cases where the Contractor wishes to conduct an activity not included in Provision 3, Paragraph A, Sub-paragraph 2) c) and d) below, Contractor shall submit a request to include the activity and obtain written, prior approval from DHCS. Contractor must submit the written request not later than 30 calendar days prior to the Marketing event, unless DHCS agrees to a shorter period.
- B. All Marketing materials, and changes in Marketing materials, including but not limited to, all printed materials, illustrated materials, videotaped and media scripts, shall be approved in writing by DHCS prior to distribution.
- C. Contractor's training and certification program and changes in the training and certification program shall be approved in writing by DHCS prior to implementation.

3. Marketing Plan

If Contractor conducts Marketing, Contractor shall develop a Marketing plan as specified below. The Marketing plan shall be specific to the Medi-Cal program only and materials shall be distributed within the Contractor's entire service area. Contractor shall implement and maintain the Marketing plan only after approval

**Exhibit A, Attachment 15
MARKETING**

from DHCS. Contractor shall ensure that the Marketing plan, all procedures and materials are accurate and do not mislead, confuse or defraud.

A. Contractor shall submit a Marketing plan to DHCS for review and approval on an annual basis. The Marketing plan, whether new, revised, or updated, shall describe the Contractor's current Marketing procedures, activities, and methods. No Marketing activity shall occur until the Marketing plan has been approved by DHCS.

- 1) The Marketing plan shall have a table of contents section that divides the Marketing plan into chapters and sections. Each page shall be dated and numbered so chapters, sections, or pages, when revised, can be easily identified and replaced with revised submissions.
- 2) Contractor's Marketing plan shall contain the following items and exhibits:
 - a) Mission Statement or Statement of Purpose for the Marketing plan.
 - b) Organizational Chart and Narrative Description
 - i. The organizational chart shall include the Marketing director's name, address, telephone and facsimile number and key staff positions.
 - ii. The description shall explain how the Contractor's internal Marketing department operates, identifying key staff positions, roles and responsibilities, and, reporting relationships including, if applicable, how the Contractor's commercial Marketing staff and functions interface with its Medi-Cal Marketing staff and functions.
 - c) Marketing Locations

All sites for proposed Marketing activities such as annual health fairs, and community events, in which the Contractor proposes to participate, shall be listed.
 - d) Marketing Activities

All Marketing methods and Marketing activities Contractor expects to use, or participate in, shall be described. Contractor shall comply with the guidelines described in Title 22 CCR Sections 53880 and 53881, Welfare and Institutions Code Sections 10850(b), 14407.1, 14408, 14409, 14410,

**Exhibit A, Attachment 15
MARKETING**

and 14411, and as follows:

- i. Contractor shall not engage in door-to-door, telephone, e-mail, texting, or other cold call Marketing for the purpose of enrolling Potential Enrollees, or for any other purpose.
- ii. Contractor shall obtain DHCS approval to perform in-home Marketing presentations and shall provide strict accountability, including documentation of the prospective Member's request for an in-home Marketing presentation or a documented telephone log entry showing the request was made.
- iii. Contractor shall not conduct Marketing presentations at primary care sites.
- iv. Include a letter or other document that verifies cooperation or agreement between the Contractor and an organization to undertake a Marketing activity together and certify or otherwise demonstrate that permission for use of the Marketing activity/event site has been granted.

e) Marketing Materials

Copies of all Marketing materials the Contractor will use for both English and non-English speaking populations shall be included.

Marketing materials shall not contain any statements that indicate that enrollment is necessary to obtain or avoid losing Medi-Cal benefits, or that the Contractor is endorsed by DHCS, the Centers for Medicare and Medicaid Services, or any other state or federal government entity.

A sample copy of the Marketing identification badge and business card that will clearly identify Marketing Representatives as employees of the Contractor shall be included. Marketing identification badges and business cards shall not resemble those of a government agency.

f) Marketing Distribution Methods

A description of the methods the Contractor will use for distributing Marketing materials.

g) Monitoring and Reporting Activities

**Exhibit A, Attachment 15
MARKETING**

Written formal measures to monitor performance of Marketing Representatives to ensure Marketing integrity pursuant to Welfare and Institutions Code Section 14408(c).

h) Miscellaneous

All other information requested by DHCS to assess the Contractor's Marketing program.

B. Contractor shall not seek to influence enrollment in conjunction with the sale or offering of any private insurance.

4. Marketing Event Notification

Contractor shall notify DHCS at least 30 calendar days in advance of Contractor's participation in all Marketing events. In cases where Contractor learns of an event less than 30 calendar days in advance, Contractor shall provide notification to DHCS immediately. In no instance shall notification be less than 48 hours prior to the event.

**Exhibit A, Attachment 16
ENROLLMENTS AND DISENROLLMENTS**

1. Enrollment Program

Contractor shall cooperate with the DHCS Enrollment program and shall provide to DHCS' enrollment contractor a provider directory, linguistic capabilities of the Providers and other information deemed necessary by DHCS to assist Eligible Beneficiaries, and Potential Enrollees, in making an informed choice in health plans. The provider directory will be submitted every six (6) months and in accordance with PL 11-009.

2. Enrollment

Contractor shall accept as Members Eligible Beneficiaries in the mandatory and voluntary aid categories as defined in Exhibit E, Attachment 1, Definitions, Eligible Beneficiaries, including Medi-Cal beneficiaries in Aid Codes who elect to enroll with the Contractor or are assigned to Contractor.

A. Enrollment - General

Eligible Beneficiaries residing within the Service Area of Contractor may be enrolled at any time during the term of this Contract. Eligible Beneficiaries shall be accepted by Contractor in the order in which they apply without regard to race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56.

B. Coverage

Member coverage shall begin at 12:01 a.m. on the first day of the calendar month for which the Eligible Beneficiary's name is added to the approved list of Members furnished by DHCS to Contractor. The term of enrollment shall continue indefinitely unless this Contract expires, is terminated, or the Member is disenrolled under the conditions described in provision 3. Disenrollment.

Contractor shall provide Covered Services to a child born to a Member for the month of birth and the following month. For a child born in the month immediately preceding the mother's membership, Contractor shall provide Covered Services to the child during the mother's first month of Enrollment. No additional Capitation Payment will be made to Contractor by DHCS.

C. Exception to Enrollment

A Member in a mandatory aid code category is not required to enroll when a request for an exemption under Title 22 CCR Section 53887 has been approved.

**Exhibit A, Attachment 16
ENROLLMENTS AND DISENROLLMENTS**

D. Enrollment Restriction

Enrollment will proceed unless restricted by DHCS. Such restrictions will be defined in writing and the Contractor notified at least ten (10) calendar days prior to the start of the period of restriction. Release of restrictions will be in writing and transmitted to the Contractor at least ten (10) days calendar prior to the date of the release. DHCS shall immediately suspend enrollment of SPD beneficiaries if DHCS determines that Contractor does not have sufficient primary or specialty Providers to meet the needs of SPD beneficiaries in accordance with W & I Code 14182(w).

3. Disenrollment

Contractor shall not request the disenrollment of a Member for any reason as stated in 42 CFR section 438.56(b). The DHCS enrollment contractor is solely responsible for processing and completing disenrollment requests and shall process a Member disenrollment under the following conditions, subject to approval by DHCS, in accordance with the provisions of Title 22 CCR Section 53891:

A. Disenrollment of a Member is mandatory when:

- 1) The Member requests disenrollment, subject to any lock-in restrictions on disenrollment under the Federal lock-in option, if applicable.
- 2) The Member's eligibility for enrollment with Contractor is terminated or eligibility for Medi-Cal is ended, including the death of the Member.
- 3) Enrollment was in violation of 22 CCR section 53891(a)(2), or requirements of this Contract regarding Marketing, and DHCS or Member requests disenrollment.
- 4) Disenrollment is requested in accordance with W&I Code section 14303.1 regarding merger with other organizations, or W&I Code section 14303.2 regarding reorganizations or mergers with a parent or subsidiary corporation.
- 5) There is a change of a Member's place of residence to outside Contractor's Service Area.

Such disenrollment shall become effective on the first day of the second month following receipt by DHCS of all documentation necessary, as determined by DHCS, to process the disenrollment, provided disenrollment was requested at least 30 calendar days prior to that date.

B. Except as provided in Paragraph A, Subparagraph 6) above, enrollment

**Exhibit A, Attachment 16
ENROLLMENTS AND DISENROLLMENTS**

shall cease no later than midnight on the last day of the first calendar month after the Member's disenrollment request and all required supporting documentation are received by DHCS. On the first day after enrollment ceases, Contractor is relieved of all obligations to provide Covered Services to the Member under the terms of this Contract. Contractor agrees in turn to return to DHCS any Capitation Payment forwarded to Contractor for persons no longer enrolled under this Contract.

- C. Contractor shall implement and maintain procedures to ensure that all Members requesting disenrollment or information regarding the disenrollment process are immediately referred to the enrollment contractor.

Two-Plan CCI Boilerplate

**Exhibit A, Attachment 17
REPORTING REQUIREMENTS**

Contract Section	Requirement	Frequency
Exhibit A - SCOPE OF WORK		
Attachment 1 ORGANIZATION AND ADMINISTRATION OF THE PLAN		
2. A. Key Personnel (Disclosure)	Key Personnel (Disclosure Form)	Annually
Attachment 2 FINANCIAL INFORMATION		
2. Financial Audit Reports B. 1) or B. 2)	Annual certified Financial Statements and DMHC required reporting forms or Financial Statement	Annually
2. Financial Audit Reports B. 2)	Quarterly Financial Reports	Quarterly
4. Monthly Financial Statements	Monthly Financial Statements (If applicable)	Monthly
Attachment 3 MANAGEMENT INFORMATION SYSTEM		
2. Encounter Data Submittal C.	Encounter Data Submittal	Monthly
6. Network Data Submissions	Network Data Submittal in the 274 Provider File	Monthly
8. Tracking Member Alternatives Selections (AFS) C.	Member AFS Data	As Requested by Member
Attachment 4 QUALITY IMPROVEMENT SYSTEM (QIS)		
4. Quality Improvement Committee C.	Quality Improvement Committee meeting minutes	Quarterly
8. Quality Improvement Annual Report	Quality Improvement Annual Report	Annually
9. External Quality Review Requirements A. External Accountability Set S) Performance Measures 2) b)	EAS Performance Measurement Rates	Annually
9. External Quality Review Requirements B. Under/Over-Utilization Monitoring	Reported rates	Annually
9. External Quality Review Requirements C. Performance Improvement projects (PIPs)	QIP Proposals or Status Reports	Annually
10. Site Review E. Data Submission	Site Review Data	Semi-Annually
Attachment 6 PROVIDER NETWORK		
11. Provider Network Reports A. B. C.	Provider Network Changes Report	Quarterly
11. Annual Provider Network Report	Provider Network Capacity Report	Annually

Two-Plan CCI Boilerplate

**Exhibit A, Attachment 17
REPORTING REQUIREMENTS**

Contract Section	Requirement	Frequency
12. Subcontractor Report	Subcontractor Report	Quarterly
Attachment 9 ACCESS AND AVAILABILITY		
13. Cultural and Linguistic Prog C. Population Needs Assessmet	Population Needs Assessment Report	Annually
Attachment 10 SCOPE OF SECES		
5. Services for Members undeTwenty -One (21) Years of Age B. Children's Preventive Serv 4)	Confidential Screening/Billing Report	Monthly
8. Services for All Members F. Pharmaceutical Services an Provision of Prescribed Drugs 1)	Report of DUR Program Activities	Annually
Attachment 12 LOCAL HEALTARTMENT COORDINATION		
4. MOU Monthly Reports	Local Health Department - MOU's County Mental Health - MOU's (If deemed necessary)	Monthly until MOU is signed
Attachment 13 MEMBER SECES		
4. Written Member Information D.	Member Services Guide	Annually
Attachment 14 MEMBER GRIEANCE AND APPEAL SYSTEM		
3. Grievance and Appeal Lognd Quarterly Grievance and Appea Report	Grievance and Appeal Report	Quarterly
3. Grievance and Appeal Lognd Grievance and Appeal Report D.	Grievance and Appeal Data	Monthly
Attachment 15 MARKETING		
3. Marketing Plan A.	Marketing Plan	Annually
Attachment 16 ENROLLMENT AND DISENROLLMENTS		
1. Enrollment Program (PL 11-009)	Provider Directory	Semi-Annually
Attachment 19 COMMUNITYASED ADULT SERVICES (CBAS)		
1. Provider Network F.	Subcontracted CBAS Providers and Accessibility Standards Report	Annually
4. Required Reports for the CBS Program B.	CBAS Enrollment Report	Quarterly
4. Required Reports for the CBS Program C.	Addition to Grievance and Appeal Report	Quarterly
Attachment 20 BEHAVIORA HEALTH SERVICES		
3. Provider Network Reports A.	Addition to the Provider Network Report	Quarterly

Two-Plan CCI Boilerplate

**Exhibit A, Attachment 17
REPORTING REQUIREMENTS**

Contract Section	Requirement	Frequency
3. Provider Network Reports B.	Non-Specialty Mental Health Services (NSMHS) Providers Report	Monthly
Attachment 21 MANAGED LONG-TERM SERVICES AND SUPPORTS (MLTSS)		
10. Required Reports for Managed Long Term Services and Supports A.	Support and Retention of Community Placement	Quarterly
10. Required Reports for Managed Long Term Services and Supports B.	Continuity of Care Requests	Monthly
10. Required Reports for Managed Long Term Services and Supports C.	Addition to the Provider Network Report	Quarterly
10. Required Reports for Managed Long Term Services and Supports D.	Addition to Grievances and Appeals Report	Monthly
10. Required Reports for Managed Long Term Services and Supports E.	PCP Assignment	Monthly
Exhibit E - ADDITIONAL PROVISIONS		
Attachment 2 PROGRAM TERMS AND CONDITIONS		
9. Certifications A. Data, Information, and Documentation Submitted to DHCS	9) Interoperability Requirements	Monthly
34. Treatment of Recoveries C. Recovery of Overpayment	Recovery of Overpayment Report	Annually

**Exhibit A, Attachment 18
IMPLEMENTATION PLAN AND DELIVERABLES**

The Implementation Plan and Deliverables section describes DHCS requirements for specific deliverables, activities, and timeframes that the Contractor must complete during the Implementation Period before beginning Operations.

Once the Contract is awarded, the Contractor has 15 calendar days after they sign the Contract to submit a Workplan for each county that describes in detail how and when the Contractor will submit and complete the deliverables to DHCS in accordance with the Implementation Plan and Deliverables section. The Contractor's Workplan(s) will include a timetable to accomplish the activities to assure timely start-up of operations and contingency plans in the event of implementation delays.

The Implementation Period begins with the effective date of the Contract and extends to the beginning of the Operations Period (approximately 6 months after the effective date of the Contract). The Operations Period is the period of time beginning with the effective date of the first month of operations and continues on through the last month of capitation and services to Members.

The Contractor's Workplan(s) will identify all of the deliverables, milestones, and timeframes to achieve an orderly sequence of events that will lead to compliance with all contract requirements. DHCS will review and approve each of the Workplan(s). However, Contractor shall not delay the submission of deliverables required in the Workplan(s) while waiting for DHCS approval of previously submitted deliverables required by the Workplan(s). Contractor will continue to submit deliverables based on the milestones and timeframes set forth in the approved DHCS Workplan(s). In the event the Contractor fails to submit all deliverables in accordance with the milestones and timeframes in the approved DHCS Workplan(s), DHCS may impose Liquidated Damages in accordance with Exhibit E, Attachment 2 – Program Terms and Conditions, Provision 17, Liquidated Damages Provisions.

In the event that this section omits a deliverable required by the Contract, the Contractor will still be responsible to assure that all contract requirements are met. Upon successful completion of the Implementation Plan and Deliverables section requirements, DHCS will authorize, in writing, that the Contractor may begin the Operations Period.

Knox-Keene Licensure

If not currently licensed to operate in awarded service area, a complete material modification to operate in the service area must be submitted to the DMHC within 30 working days of award of contract. Submit proof of the material modification submission to DHCS concurrently. Operation shall not begin until the material modification is approved by DMHC. Contractor shall submit a copy of their Knox-Keene license.

**Exhibit A, Attachment 18
IMPLEMENTATION PLAN AND DELIVERABLES**

1. Organization and Administration of Plan

- A. Submit documentation of employees (current and former State employees) who may present a conflict of interest.
- B. Submit a complete organizational chart.
- C. If the Contractor is a subsidiary organization, submit an attestation by the parent organization that this Contract will be a high priority to the parent organization.
- D. Submit an attestation that the medical decisions made by the medical director will not be unduly influenced by fiscal or administrative management.
- E. Submit policies and procedures describing the representation and participation of Medi-Cal Members on Contractor's Public Policy Advisory Committee.
- F. Submit the following Knox-Keene license exhibits and forms reflecting current operation status:
 - 1) Type of Organization: Submit the following applicable exhibits and forms as appropriate for its type of organization and administration of the health plan.
 - i. Corporation: Exhibits F-1-a-i through F-1-a-iii as referenced in Title 28 CCR 1300.51
 - ii. Partnership: Exhibits F-1-b-i and F-1-b-ii as referenced in Title 28 CCR 1300.51
 - iii. Sole Proprietorship: Exhibit F-1-c as referenced in Title 28 CCR 1300.51
 - iv. Other Organization: Exhibits F-1-d and F-1-d-ii as referenced in Title 28 CCR 1300.51
 - v. Public Agency: Exhibits F-1-e-I through F-1-e-iii as referenced in Title 28 CCR 1300.51.

Title 28, CCR, Section 1300.51(d)(F)(1)(a) through (e)
 - 2) Exhibit F-1-f: Individual Information Sheet (Form HP 1300.51.1) for each person named in response to item 1) above. Title 28, CCR, Section 1300.51(d)(F)(1)(f)
 - 3) Exhibits F-2-a and F-2-b: contracts with Affiliated person, Principal

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Creditors and Providers of Administrative Services.

- 4) Exhibit F-3 Other Controlling Persons.

Title 28, CCR, Section 1300.51(d)(F)

- 5) In addition to Exhibits F, Contractor shall demonstrate compliance with requirements of Title 22 CCR Sections 53874 and 53600. Identify any individual named in this item b. that was an employee of the State of California in the past 12 months. Describe their job position and function while a State employee.

- G. Submit Exhibit M-2: Statements as to each person identified in Section L. Technical Proposal Requirements, Provision 1. Organization and Administration, a. 2) (Exhibit L) and 3). (Exhibit M-1)

Title 28, CCR, Section 1300.51(d)(M)(2)

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

Title 28, CCR, Section 1300.51(d)(N)(2)

- I. If, within the last five (5) years, Contractor has had a contract terminated or not renewed for poor performance, nonperformance, or any other reason, Contractor shall submit a summary of the circumstances surrounding the termination or non-renewal. Describe the parties involved, including address(es) and telephone number(s). Describe the Contractor's corrective actions to prevent future occurrences of any problems identified.

- J. Contractor shall describe provisions and arrangements, existing, and proposed, for including Medi-Cal Members in their Public Policy Advisory Committee development process. Identify the composition and meeting frequency of any committee participating in establishing the Contractor's public policy. Describe the frequency of the committee's report submission to the Contractor's Governing Body, and the Governing body, and the Governing Body's process for handling reports and recommendations after receipt.

- K. Contractor shall submit policies and procedures for ensuring that all appropriate staff receives sensitivity training relating to SPD beneficiaries.

2. Financial Information

All submitted financial information must adhere to Generally Accepted Accounting Principles (GAAP), unless otherwise noted.

Note: Where Knox-Keene license exhibits are requested, the descriptions of

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exhibit content may have been amended to address Medi-Cal program needs or industry terminology.

- A. Submit most recent audited annual financial reports
- B. Submit quarterly Financial Statements with the most recent quarter prior to execution of the Contract.
- C. Submit the following Knox-Keene license exhibits reflecting projected financial viability:
 - 1) Exhibit HH-1
 - 2) Exhibit HH-2

Title 28, CCR, Section 1300.76

 - 3) In addition to Exhibit HH-2, include projected Medi-Cal enrollment for each month and cumulative Member months for quarterly financial projections.
- D. Submit Knox-Keene license Exhibit HH-6. Include the following:
 - 1) Exhibit HH-6-a
 - 2) Exhibit HH-6-b
 - 3) Exhibit HH-6-c
 - 4) Exhibit HH-6-d
 - 5) Exhibit HH-6-e

Title 28, CCR, Section 1300.51(d)(HH)
- E. Describe any risk sharing or incentive arrangements. Explain any intent to enter into a stop loss option with DHCS. Also describe any reinsurance and risk-sharing arrangements with any Subcontractors shown in this Contract. Submit copies of all policies and agreements. For regulations related to Assumption of Financial Risk and Reinsurance, see Title 22 CCR Sections 53863 and 53868.
- F. Fiscal Arrangements: Submit the following Knox-Keene license exhibits reflecting current operation status:
 - 1) Exhibit II-1
 - 2) Exhibit II-2

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3) Exhibit II-3

Title 28, CCR, Section 1300.51(d)(II)

- G. Describe systems for ensuring that Subcontractors and Network Providers, who are at risk for providing services to Medi-Cal Members, as well as any obligations or requirements delegated pursuant to a Subcontractor Agreement or Network provider Agreement, have the administrative and financial capacity to meet its contractual obligations in accordance with Title 28 CCR Section 1300.70(b)(2)(H)1 and Title 22 CCR Section 53250.
- H. Submit financial policies that relate to Contractor's systems for budgeting and operations forecasting. The policies should include comparison of actual operations to budgeted operations, timelines used in the budgetary process, number of years prospective forecasting is performed, and variance analysis and follow-up procedures.
- I. Describe process to ensure timely filing of required financial reports. The description should include mechanisms for systems oversight for generating financial and operational information, including a tracking system with lead times and due dates for quarterly and annual reports. Describe how this process coincides with the organization's management information system. Additionally, Contractor shall describe how it will comply with the Administrative cost requirements in Title 22 CCR Section 53864(b).
- J. Submit policies and procedures for a system to evaluate and monitor the financial viability of all Network Providers and Subcontractors that accept financial risk for the provision of Covered Services.

3. Management Information System (MIS)

- A. Submit a completed MCO Baseline Assessment Form.
- B. If procuring a new MIS or modifying a current system, Contractor shall provide a detailed implementation plan that includes:
 - 1) Outline of the tasks required;
 - 2) The major milestones;
 - 3) The responsible party for all related tasks;

The implementation plan must also include:

- 1) A full description of the acquisition of software and hardware, including the schedule for implementation;

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- 2) Full documentation of support for software and hardware by the manufacturer or other contracted party;
 - 3) System test flows through a documented process that has specific control points where evaluation data can be utilized to correct any deviations from expected results;
 - 4) Documentation of system changes related to Exhibit G, Health Insurance Portability and Accountability Act (HIPAA) requirements.
- C. Submit a detailed description, including a diagram and/or flow chart, of how Contractor will monitor the flow of Encounter Data from origination at the Provider level to Contractor, through submission to DHCS.
- D. Submit an Encounter Data test produced using real or proxy data processed by a new or modified MIS to DHCS. Monthly encounter submissions from a new or modified MIS may not take place until this test has been successfully completed and approved by DHCS.
- E. Submit policies and procedures for the submission of complete, accurate, timely, and reasonable Encounter Data.
- F. Submit a work plan for compliance with Exhibit G, Health Insurance Portability and Accountability Act (HIPAA).
- G. Submit the data security, backup, or other data disaster processes used in the event of a MIS failure.
- H. Submit a detailed description of the proposed and/or existing MIS as it relates to the following subsystems;
- 1) Financial
 - 2) Member/Eligibility
 - 3) Provider
 - 4) Encounter/Claims
 - 5) Quality Management/Utilization
- I. Submit a sample and description of the following reports generated by the MIS;
- 1) Member roster
 - 2) Provider Listing
 - 3) Capitation Payments

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- 4) Cost and Utilization
- 5) System edits/audits
- 6) Claims payment status/processing
- 7) Quality Assurance
- 8) Utilization
- 9) Monitoring of Complaints

- J. Submit policies and procedures for the submission of complete, accurate, and timely Network data to DHCS.

- K. Submit policies and procedures to demonstrate how Contractor will conduct routine testing and monitoring, and update their systems as appropriate to ensure the APIs are functioning properly and complying with HIPAA requirements.

4. Quality Improvement System

- A. Submit a flow chart and/or organization chart identifying all components of the QIS and who is involved and responsible for each activity.
- B. Submit policies that specify the responsibility of the governing body in the QIS.
- C. Submit policies for the QI Committee including membership, activities, roles and responsibilities.
- D. Submit procedures outlining how Providers will be kept informed of the written QIS, its activities and outcomes.
- E. Submit policies and procedures related to the delegation of the QIS activities.
- F. Submit boilerplate Subcontractor Agreement language showing accountability of delegated QIS functions and responsibilities.
- G. Submit a written description of the QIS.
- H. Policies and procedures to address how the Contractor will meet the requirements of:
 - 1) External Accountability Set (EAS) Performance Measures
 - 2) Performance Improvement Projects

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- 3) Consumer Satisfaction Survey
 - 4) Network Adequacy Validation
 - 5) Encounter Data Validation
 - 6) Focused Studies
 - 7) Technical Assistance
- I. Submit policies and procedures for performance of Facility Site and Medical Record reviews (FSR Attachments A and B), and for performance of Facility Site Physical Accessibility reviews (FSR Attachment C).
 - J. Submit a list of sites to be reviewed prior to initiating plan operation
 - K. Submit the aggregate results of pre-operational site review to DHCS at least six (6) weeks prior to Plan operation. The aggregate results shall include all data elements defined by DHCS.
 - L. Submit policies and procedures for reporting any disease or condition to public health authorities.
 - M. Submit policies and procedures for credentialing and re-credentialing.
 - N. Submit policies and procedures for appropriate handling and maintenance of medical records regardless of form (electronic, paper, etc.).
- 5. Utilization Management (UM)**
- A. Submit written description of UM program that describes appropriate processes to be used to review and approve the provision of medical, mental health, and substance use disorder services to demonstrate compliance with mental health parity. Also include the processes to be used for the provision of Medically Necessary Behavioral Health Treatment (BHT) services.
 - B. Submit policies and procedures for Prior Authorization, concurrent review, and retrospective review.
 - C. Submit a list of services requiring Prior Authorization and the utilization review criteria.
 - D. Submit policies and procedures for the utilization review appeals process for Providers and Members.
 - E. Submit policies and procedures that specify timeframes for medical authorization.

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- F. Submit policies and procedures to detect both under- and over-utilization of health care services.
- G. Submit policies and procedures showing how delegated activities will be regularly evaluated for compliance with Contract requirements and, that any issues identified through the UM program are appropriately resolved; and that UM activities are properly documented and reported.
- H. Submit policies and procedures for utilization management for organ and bone marrow transplant surgeries and related services.

6. Provider Network

- A. Submit complete Provider Network showing the ability to serve sixty percent (60%) of the Eligible Beneficiaries, including SPD beneficiaries, in the county pursuant to the Contract.
- B. Submit policies and procedures describing how Contractor will monitor Provider to Member ratios to ensure they are within specified standards.
- C. Submit policies and procedures regarding Physician supervision of Non-Physician Medical Practitioners.
- D. Submit policies and procedures for providing Emergency Services.
- E. Submit a complete list of Specialists by type within Contractor's Network.
- F. Submit policies and procedures for how Contractor will meet federal requirements for access and reimbursement to Network and/or out-of-Network Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), and Freestanding Birthing Center (FBC) services.
- G. Submit a GeoAccess report (or similar) showing that the proposed Provider Network meets the appropriate time or distance standards set forth in the Contract.
- H. Submit a policy regarding the availability of a health plan physician 24-hours-a-day, 7-days-a-week, and procedures for communicating with emergency room personnel.
- I. Submit policies and procedures for how Contractor will ensure Network Provider hours of operation are no less than the hours of operation offered to other commercial or FFS patients.
- J. Submit a report containing the names of all Subcontractors (see Exhibit A, Attachment 6, Provision 12).
- K. Submit an analysis demonstrating the ability of the Contractor's Provider Network to meet the ethnic, cultural, and linguistic needs of Contractor's

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Members.

- L. Submit policies and procedures for ensuring Network Providers and Subcontractors fully comply with all applicable terms and conditions of this Contract.
- M. Submit all boilerplate Network Provider Agreements and Subcontractor Agreements.
- N. Submit policies and procedures that establish Traditional and Safety-Net Provider participation standards.
- O. Submit an attestation as to the percentage of Traditional and Safety-Net Providers in the Contractor's Network and agreement to maintain that percentage.
- P. Submit policies and procedures for the screening and enrollment of Network Providers.

7. Provider Relations

- A. Submit policies and procedures for Provider grievances.
- B. Submit a written description of how Contractor will communicate the Provider Grievance process to Network Providers and Out-of-Network Providers.
- C. Submit protocols for payment and communication with Out-of-Network Providers.
- D. Submit copy of Contractor's Network Provider manual.
- E. Submit a schedule of Network Provider training to be conducted during year one of operation. Include date, time and location, and complete curriculum.
- F. Submit policies and procedures for ensuring Network Providers receive training on a continuing basis regarding clinical protocols, evidenced-based practice guidelines, and DHCS developed cultural awareness and sensitivity instruction for SPD beneficiaries.
- G. Submit policies and procedures for ensuring Out-of-Network Providers receive Contractor's clinical protocols and evidence-based practice guidelines.
- H. Submit protocols for communicating and interacting with all emergency departments in the Service Area.

8. Provider Compensation Arrangements

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- A. Submit policies and procedures regarding timing of Capitation Payments to Primary Care Providers or clinics.
- B. Submit description of any physician incentive plans.
- C. Submit policies and procedures for processing and payment of claims.
- D. Submit policies regarding the prohibition of a claim or demand for services provided under the Medi-Cal managed care contract to any Member.
- E. Submit FQHC, RHC, and American Indian Health Service Programs Subcontractor Agreements and Network Provider Agreements, as applicable.
- F. Submit policies and procedures for the reimbursement of Non-Contracting Certified Nurse Midwives (CNM) and Certified Nurse Practitioners (CNP).
- G. Submit policies and procedures for the reimbursement to local health department and non-contracting family planning Providers for the provision of family planning service, STD episode, and HIV testing and counseling.
- H. Submit policies and procedures for the reimbursement of immunization services to local health department.
- I. Submit policies and procedures regarding payment to non-contracting Emergency Services Providers. Include schedule of per diem rates and/or FFS rates for each of the following Provider types;
 - 1) Primary Care Providers
 - 2) Medical Groups and Independent Practice Associations
 - 3) Specialists
 - 4) Hospitals
- J. Submit policies and procedures for reporting Provider-Preventable Conditions.

9. Access and Availability

- A. Submit policies and procedures that include requirements for:
 - 1) Appointment scheduling
 - 2) Routine specialty referral
 - 3) First prenatal visit

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- 4) Waiting times
 - 5) After-hours calls
 - 6) Unusual specialty services
- B. Submit policies and procedures for ensuring the timely provision of access standards for:
- 1) Appropriate clinical timeframes
 - 2) Standards for timely appointments
 - 3) Shortening or expanding timeframes
 - 4) Arranging timely appointments with a Provider shortage.
- C. Submit policies and procedures for the timely referral and coordination of Covered Service to which Contractor or Subcontractor has objections to perform or otherwise support.
- D. Submit policies and procedures for standing referrals.
- E. Submit policies and procedures regarding 24-hr/day access without prior authorization, follow-up and coordination of emergency care services.
- F. Submit policies and procedures regarding access to Certified Nurse Midwives and Certified Nurse Practitioners.
- G. Submit applicable section of Member Services Guide stating Member's right to access family planning services without prior authorization.
- H. Submit policies and procedures for the provision of and access to:
- 1) Family planning services
 - 2) Sexually transmitted disease treatment
 - 3) HIV testing and counseling services
 - 4) Pregnancy termination
 - 5) Minor consent services
 - 6) Immunizations
- I. Submit policies and procedures regarding access for disabled members pursuant to the Americans with Disabilities Act of 1990.

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- J. Submit policies and procedures regarding Contractor, Network Provider, and Subcontractor compliance with the Civil Rights Act of 1964.
- K. Submit policies and procedures regarding compliance with the Americans with Disabilities Act of 1990, Section 504 of the Rehabilitation Act, Section 1557 of the Patient Protection and Affordable Care Act, SB 223/SB 1423, and Gov. Code Section 11135, as required in APL 20-015
- L. Submit a written description of the Cultural and Linguistic Services Program.
- M. Submit a timeline and work plan for the development and performance of a Population Needs Assessment.
- N. Submit policies and procedures for providing cultural competency, sensitivity or diversity training for staff and Network Providers.
- O. Submit policies and procedures for monitoring and evaluation of the Cultural and Linguistic Services Program.
- P. Submit policies and procedures for the provision of 24-hour interpreter services at Network Provider sites.
- Q. Submit policies and procedures describing the membership of the Community Advisory Committee (CAC) and how Contractor will ensure the CAC will be involved in appropriate policy decisions.
- R. Submit policies and procedures for providing Medically Necessary Covered Services through Out-of-Network Providers, including allowing access for the completion of Covered Services by an Out-of-Network Provider or terminated Network Provider.
- S. Submit policies and procedures to ensure access for up to 12 months for SPD beneficiaries who have an ongoing relationship with a Out-of-Network Provider.
- T. Submit the necessary documentation and reporting as required by DHCS to ensure that Contractor can establish and demonstrate compliance in determining access to Out-of-Network Providers for mental health and substance use disorder benefits with the requirements set forth in this Contract and in 42 CFR part 438, subpart K.

10. Scope of Services

- A. Submit policies and procedures for ensuring the provision of the Initial Health Assessments (IHA) for adults and children, including the Individual Health Education Behavioral Health Assessment (IHEBA) of the IHA.

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- B. Submit policies and procedures for administering the Health Risk Stratification and Assessment to SPD beneficiaries, including other health information used for risk stratification.
- C. Submit Contractor's risk stratification mechanism or algorithm designed for the purpose of identifying newly enrolled SPD beneficiaries as high or low risk.
- D. Submit the plan's risk assessment tool to be used to comprehensively assess an SPD beneficiaries' current health risk and help develop individualized care management plans.
- E. Submit policies and procedures, including standards, for the provision of the following services for Members under 21 years of age:
 - 1) Children's Preventive Services
 - 2) Immunizations
 - 3) Screening for Childhood Lead Poisoning
 - 4) EPSDT Services
- F. Submit policies and procedures for the provision of adult preventive services, including immunizations.
- G. Submit policies and procedures for the provision of services to pregnant women, including:
 - 1) Prenatal care
 - 2) Use of American College of Obstetricians and Gynecologists (ACOG) standards and guidelines
 - 3) Comprehensive risk assessment tool for all pregnant women
 - 4) Referral to Specialists
- H. Submit a list of appropriate hospitals available within the Provider Network that provide necessary high-risk pregnancy services.
- I. Provide a detailed description of health education system including policies and procedures regarding delivery of services, administration and oversight.
- J. Provide a list and schedule of all health education classes and/or programs.
- K. Submit policies and procedures for the distribution and use of the Health

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Information Form (HIF) data submitted through the Member Evaluation Tool (MET).

- L. Submit policies and procedures for the provision of:
 - 1) Hospice care
 - 2) Vision care – Lenses
 - 3) Mental health services
 - 4) NEMT/NMT
 - 5) Organ and bone marrow transplant surgeries
- M. Submit policies and procedures for conducting a Drug Utilization Review (DUR).
- N. Submit the necessary documentation and reporting as required by DHCS to ensure that Contractor establish and demonstrate compliance with the requirements in this Contract and in 42 CFR part 438, subpart K, for the following:
- O. Submit policies and procedures regarding the authorization of Medically Necessary Physician administered drugs billed on a medical and/or institutional claim needed for organ and bone marrow transplants.

11. Case Management and External Coordination of Care

- A. Submit policies and procedures for administration of a disease management program, including procedures for identification and referral of Members eligible to participate in the disease management program.
- B. Submit policies and procedures for referral and coordination of care for Members in need of Specialty Mental Health Services from the county mental health plan or other community resources.
- C. Submit policies and procedures for resolving disputes between Contractor and the county mental health plan.
- D. Submit policies and procedures for identification, referral and coordination of care for Members requiring alcohol or substance use treatment services from both within and, if necessary, outside Contractor's Service Area.
- E. Submit a detailed description of Contractor's program for Children with Special Health Care Needs (CSHCN).
- F. Submit policies and procedures for identifying and referring children to the local CCS program.

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- G. Submit policies and procedures for the identification, referral and coordination of care for Members with developmental disabilities in need of non-medical services from the local Regional Center and the DDS-administered Home and Community Based Waiver Program. Include the duties of the Regional Center Liaison.
- H. Submit policies and procedures for the identification, referral and coordination of care for Members at risk of developmental delay and eligible to receive services from the local Early Start Program.
- I. Submit policies and procedures for case management coordination of care of LEA services, including Primary Care Physician involvement in the development of the Member's Individual Education Plan or Individual Family Service Plan.
- J. Submit policies and procedures for case management coordination of care of Members who receive services through local school districts or school sites.
- K. Submit a description of the cooperative arrangement Contractor has with the local school districts, including the Network Provider Agreements, Subcontractor Agreements, or written protocols/guidelines, if applicable.
- L. Submit policies and procedures describing the cooperative arrangement that Contractor has regarding care for children in Foster Care.
- M. Submit policies and procedures for identification and referral of Members eligible to participate in the HIV/AIDS Home and Community Based Waiver Program.
- O. Submit policies and procedures for the provision of dental screening and covered medical services related to dental services.
- P. Submit policies and procedures for coordination of care and case management of Members with the LHD TB Control Officer.
- Q. Submit policies and procedures for the assessment and referral of Members with active TB and at risk of non-compliance with TB drug therapy to the LHD.
- R. Procedures to identify and refer eligible Members for WIC services.
- S. Submit policies and procedures for the assessment and subsequent disenrollment of Members eligible for Long-Term Care and Waiver Program.

12. Local Health Department Coordination

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- A. Submit executed Network Provider Agreements and Subcontractor Agreements, as applicable, or documentation substantiating Contractor's efforts to enter into these agreements with the LHD for the following public health services:
 - 1) Family planning services
 - 2) STD services
 - 3) HIV testing and counseling
 - 4) Immunizations

- B. Submit executed Network Provider Agreements and Subcontractor Agreements, as applicable, Memoranda of Understanding, or documentation substantiating Contractor's efforts to negotiate an agreement with the following programs or agencies:
 - 1) California Children Services (CCS)
 - 2) Maternal and Child Health
 - 3) Child Health and Disability Prevention Program (CHDP)
 - 4) Tuberculosis Direct Observed Therapy
 - 5) Women, Infants, and Children Supplemental Nutrition Program (WIC)
 - 6) Regional Centers for Services for Persons with Developmental Disabilities.
 - 7) Local Governmental Agencies for Targeted Case Management services.
 - 8) County department for alcohol and substance use disorder treatment services.

- C. Executed MOU or documentation substantiating Contractor's efforts to negotiate a MOU with the county mental health plan.

13. Member Services

- A. Submit policies and procedures that address Member's rights and responsibilities. Include method for communicating them to both Members and Providers.

- B. Submit policies and procedures for providing communication access to SPD beneficiaries in alternative formats or through other methods that

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ensure communication, including assistive listening systems, sign language interpreters, captioning, written communication, plain language or written translations and oral interpreters, including for those who are limited English-proficient (LEP), or non-English speaking.

- C. Submit the following consistent with the requirements of Exhibit E, Attachment 2, Provision 21, Confidentiality of Information. Submit policies addressing Member's rights to confidentiality of medical information. Include procedures for release of medical information.
- D. Submit policies and procedures for addressing advance directives.
- E. Submit policies and procedures for the training of Member Services staff.
- F. Submit policies and procedures regarding the development content and distribution of Member information. Address appropriate reading level and translation of materials.
- G. Submit final draft of Member Identification Card and Member Services Guide.
- H. Submit policies and procedures for notifying Members of changes in availability or location of Covered Services.
- I. Submit policies and procedures for Member selection of a Primary Care Physician or Non-Physician Medical Practitioner. Include the mechanism used for allowing SPD beneficiaries to request a Specialist to serve as their PCP.
- J. Submit policies and procedures for Member assignment to a Primary Care Physician. Include the use of utilization data and other data in linking a SPD beneficiary to a PCP.
- K. Submit policies and procedures for notifying a Primary Care Provider that a Member has selected or been assigned to the Provider within seven (7) days.
- L. Submit policies and procedures demonstrating how, upon entry into Contractor's Network, the relationship between Traditional and Safety-Net Providers and their patients is not disrupted, to the maximum extent possible.
- M. Submit policies and procedures for notifying Members for denial, deferral, or modification of requests for Prior Authorization.
- N. Submit policies and procedures to demonstrate how, for dates of service on or after January 1, 2016, Contractor will make the data it maintains available within one (1) Working Day of receipt data or information, or one

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(1) Working Day after a claim is adjudicated or Encounter Data is received.

- O. Submit policies and procedures to demonstrate how Contractor will update its provider directory API at least weekly after receiving updated Provider information or being notified of any information that affects the content or accuracy of the provider directory.
- P. Submit website mock-ups showing where a third-party applicant can easily access Contractor's patient access and provider directory APIs.
- Q. Submit a link to Contractor's publicly accessible Member educational resources that will achieve the following:
 - 1) Demonstrate the steps Member may consider taking to help protect the privacy and security of their health information and the importance of understanding the security and privacy practices of any application to which they entrust their health information; and
 - 2) Provide an overview of which types of organizations or individuals are and are not likely to be HIPAA covered entities, the oversight responsibilities of the Office for Civil Rights (OCR) and the Federal Trade Commission (FTC), and how to submit a complaint to OCR and FTC.

14. Member Grievance and Appeal System

- A. Submit policies and procedures relating to Contractor's Member Grievance and Appeal System.
- B. Submit policies and procedures for Contractor's oversight of their Grievance and Appeal System for the receipts, processing and distribution including the expedited review of Appeals. Include a flow chart to demonstrate the process.
- C. Submit format for Quarterly Grievance and Appeal Log and Report.
- D. Submit policies and procedures relating to Contractor's Appeals process. Include Contractor's responsibilities in expedited Appeals and State Hearings.

15. Marketing

- A. Submit policies and procedures for training and certification of Marketing Representatives.
- B. Submit a description of training program, including the marketing representative's training/certification manual.

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- C. Submit Contractor's marketing plan.
- D. Submit copy of boilerplate request form used to obtain DHCS approval of participation in a marketing event.

16. Enrollments and Disenrollments

- A. Submit policies and procedures for how Contractor will update and maintain accurate information on its contracting Providers.
- B. Submit policies and procedures for how Contractor will access and utilize enrollment data from DHCS.
- C. Submit policies and procedures relating to Member disenrollment.

17. Health Insurance Portability and Accountability Act (HIPAA)

Submit the following consistent with the requirements of Exhibit G.

- A. Submit policies and procedures for compliance with the Health Insurance Portability and Accountability Act of 1996.

18. Community Based Adult Services (CBAS)

Submit the following consistent with the requirements of Exhibit A, Attachment 19.

- A. Submit policies and procedures for referring a Member to a CBAS Provider.
- B. Submit policies and procedures on arranging for the provision of CBAS unbundled services.
- C. Submit all policies and procedures on providing CBAS Emergency Remote Services (ERS).
- D. Submit policies and procedures for the initial assessment and reassessment of Members for eligibility to receive CBAS, including circumstances where Contractor may forgo a face-to-face review if eligibility has already been determined through another process.
- E. Submit policies and procedures for an expedited assessment process.
- F. Submit final draft of the written notice to be sent to Members after a CBAS assessment determination that results in a change to the Member's CBAS benefit.
- G. Submit policies and procedures for community participation for Members

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receiving CBAS.

- H. Submit policies and procedures for notifying DHCS of payments made to a CBAS Provider involved in a credible allegation of fraud.

19. Behavioral Health Services

Submit the following consistent with the requirements of Exhibit A, Attachment 20.

- A. Submit policies and procedures for adding licensed mental health Providers to the Network, including which services shall be offered by licensed mental health Providers.
- B. Submit policies and procedures for ensuring timely access to Non-Specialty Mental Health Services (NSMHS).
- C. Submit any Network Provider Agreement and Subcontractor Agreement boilerplate developed for a county mental health plan.
- D. Submit policies and procedures for entering into Agreements with county mental health plans in order to comply with access standards.
- E. Submit policies and procedures for verifying the credentials of licensed mental health Providers of NSMHS.
- F. Submit policies and procedures for contracting with out-of-Network and Tele-health mental health services Providers.
- G. Submit policies and procedures for exchanging Member information with the county mental health plan.
- H. Submit policies and procedures for handling of psychiatric emergencies during non-business hours.
- I. Submit policies and procedures that define and describe what mental health services are to be provided by a licensed mental health care Provider.
- J. Submit policies and procedures for when a Member becomes eligible for Specialty Mental Health Services during the course of receiving medically necessary NSMHS.
- K. Submit policies and procedures for the provision of Alcohol Misuse Screening and Counseling (AMSC) services, including:
 - 1) Provision of AMSC by a Member's PCP to identify, reduce, and

**Exhibit A, Attachment 18
IMPLEMENTATION PLAN AND DELIVERABLES**

prevent problematic substance use;

- 2) Referral, without requiring Prior Authorization, to AMSC services for Members whose PCPs do not offer AMSC; and
- 3) Referral of Members to substance use disorder treatment without requiring Prior Authorization, when there is a need beyond AMSC.

20. Managed Long-Term Services and Supports

Submit the following consistent with the requirements of Exhibit A, Attachment 21.

- A. Submit policies and procedures for the provision of services at non-contracted Long Term Care (LTC) facilities.
- B. Submit an addition to the policies and procedures related to Provider training required in Provision 7 of this Attachment that includes key elements of operating a successful program for administering MLTSS.
- C. Submit policies and procedures for the provision of LTC as a Covered Service.
- D. Submit policies and procedures for the provision of continuity of care through continued access to either a CBAS Provider with whom there is an existing relationship for up to 12 months after Full Benefit Dual Eligible Member enrollment or an LTC Provider with whom there is an existing relationship until December 31, 2016.
- E. Submit policies and procedures for the risk stratification process conducted for Full Benefit Dual Eligible, Partial Dual Eligible, and Medi-Cal Only Members.
- F. Submit policies and procedures for the development of an Individual Care Plan (ICP) and assembling an Interdisciplinary Care Team (ICT) for Medi-Cal Only Members who are assessed to be high risk.
- G. Submit policies and procedures for using utilization data to establish existing Provider relationships for Full Benefit Dual Eligible Members, Partial Dual Eligible Members, and Medi-Cal Only Members.

21. Case Management and Internal Coordination of Care

Submit the following consistent with the requirements of Exhibit A, Attachment 22.

- A. Submit procedures for monitoring the coordination of care provided to Members. Include procedures used to monitor the provision of Basic Case

**Exhibit A, Attachment 18
IMPLEMENTATION PLAN AND DELIVERABLES**

Management.

- B. Submit procedures for administering and monitoring the provision of Complex Case Management to Members. Include procedures to identify Members who may benefit from Complex Case Management services.
- C. Submit policies and procedures for ensuring the provision of Person-Centered Planning for SPD beneficiaries as part of case management and internal coordination of care.
- D. Submit policies and procedures for ensuring the provision of Discharge Planning.
- E. Submit policies and procedures for coordinating care of Members who are receiving services from a Targeted Case Management Provider.
- F. Submit policies and procedures for the referral of Members under the age of 21 years who require Complex Case Management services.
- G. Submit policies and procedures for assessment of transitional needs of Members into and out of Complex Case Management services:
 - 1) At the request of the PCP or Member
 - 2) Achievement of targeted outcomes
 - 3) Change of healthcare setting
 - 4) Loss or change in benefits
 - 5) Member non-compliance
- H. Submit policies and procedures for coordinating care of Members who are receiving services from Enhanced Care Management Provider.
- I. Submit policies and procedures for administering and monitoring the provision of Community Supports to Members. Include procedures to identify Members who may benefit from Community Supports.

22. Budget Detail and Payment Provisions

Submit documentation of the Coordination of Benefits Agreement (COBA) that Contractor has entered into with Medicare.

23. Program Terms and Conditions

- A. Submit policies and procedures explaining Contractor's data certification

**Exhibit A, Attachment 18
IMPLEMENTATION PLAN AND DELIVERABLES**

reporting method. Policies and procedures must include a template certification statement.

- B. Submit policies and procedures for the treatment of recoveries, including retention policies, process, timeframes, and documentation for reporting, for all recovery of Overpayments.

**Exhibit A, Attachment 19
COMMUNITY BASED ADULT SERVICES (CBAS)**

1. Provider Network

In addition to Exhibit A, Attachment 6, Provider Network, Contractor also agrees to the following:

- A. Contract with a sufficient number of available CBAS Providers in Contractor's Services Area to meet the expected utilization without a waitlist and ensure timely access, within on hour's transportation time, for Members who meet the CBAS eligibility criteria in the California CalAIM 1115(a) Demonstration, Number 11-W-00193/9 (CalAIM Demonstration) Special Terms and Conditions (STC), General Program Requirement (GPR) .A.19.a and d. CBAS Providers must be appropriate for and proficient in addressing CBAS-eligible Members' specialized health care needs, and their acuity, communication, cultural, and language needs and preferences. Contractor shall confirm that every subcontracted CBAS Provider is licensed, certified, enrolled in Medi-Cal, and meets Contractor's credentialing and quality standards, including required Medi-Cal enrollment of staff.
- B. Ensure that every CBAS Provider within their Service Area certified by the California Department of Aging (CDA) as a CBAS Provider, is included in Contractor's Network, to the extent that the CBAS Provider remains licensed as an Adult Day Health Care (ADHC) Center, certified and enrolled as a Medi-Cal Provider, is willing to enter into a Network Provider agreement with Contractor on mutually agreeable terms, and meets Contractor's credentialing and quality standards. Contractor may, but is not obligated to, contract with CBAS Providers licensed as an ADHC and certified by the CDA to provide CBAS on or after April 1, 2012.
- C. If Contractor determines that Member needs for CBAS exceeds Contractor's CBAS Provider capacity, if there is insufficient CBAS Provider capacity due to closure(s) to satisfy demand in the Service Area, or if there is a 5% drop in the capacity in a county within the Service Area from April 1, 2012, Contractor shall arrange for access to unbundled services in accordance with the CalAIM Demonstration STCs, GPRs V.A.19.b.iii.1 and V.A.23.a.iv.
- D. Contractor may exclude any CBAS Provider from its Network, to the extent that the Contractor and CBAS Provider cannot agree to terms, the CBAS Provider does not meet Contractor's credentialing or quality standards, is terminated pursuant to the terms of the CBAS Provider's contract with Contractor, or otherwise ceases its operations as a CBAS Provider.
- E. Contractor shall pay subcontracted CBAS Providers with a reimbursement structure that is either an all-inclusive rate per Member per day of

**Exhibit A, Attachment 19
COMMUNITY BASED ADULT SERVICES (CBAS)**

attendance, or that is otherwise reflective of the acuity and/or level of care of the Member population served by CBAS Providers.

- 1) In addition to Exhibit A, Attachment 8, Provider Compensation Arrangements and in accordance with W & I Code Section 14184.201(d)(4), Contractor shall reimburse contracted CBAS Providers at the Fee-for-Service Medi-Cal rate, unless Contractor and the CBAS Provider mutually agree to a different reimbursement amount.
- 2) Contractor may include incentive payment adjustments and performance and/or quality standards in its reimbursement structure for CBAS Providers.

F. Contractor shall provide DHCS with a list of its subcontracted CBAS Providers and its CBAS accessibility standards on an annual basis.

2. Covered Services

In addition to Exhibit A, Attachment 10, Provision 1, Covered Services and in accordance with the CalAIM Demonstration STCs, GPRs V.A.20.a and b, Contractor shall cover CBAS and ensure provision of the following services:

- A. Arrange for the provision of CBAS to Members determined eligible to receive CBAS core services, and additional services as needed, in accordance with the CalAIM Demonstration STCs, GPR V.A.23.b, and Provision 3 below.
- B. Consider a Member's relationship with a previous Provider of services similar to CBAS when referring a Member to a CBAS Provider.
- C. Cover CBAS as a bundled service through a CBAS Provider or arrange for the provision of unbundled CBAS based on the assessed needs of the Member if a certified CBAS Provider is not available or not contracted, or there is insufficient CBAS Provider capacity in the area. Arranging for unbundled CBAS includes authorizing Covered Services and coordinating with community resources to assist Members whose CBAS Providers have closed, and Members who have similar clinical conditions as CBAS Members, to remain in the community. Unbundled services authorized by Contractor are limited to:
 - 1) Professional Nursing Services;
 - 2) Nutrition;
 - 3) Physical Therapy;

**Exhibit A, Attachment 19
COMMUNITY BASED ADULT SERVICES (CBAS)**

- 4) Occupational Therapy;
 - 5) Speech and Language Pathology Services;
 - 6) NEMT and NMT, only between a Member's home and the CBAS unbundled service Provider; and
 - 7) Non-Specialty Mental Health Services and substance use disorder services that are Covered Services.
- D. Arrange for the provision of CBAS Emergency Remote Services (ERS), in response to a Member's needs, and in accordance with CalAIM Demonstration STCs, GPR V.A.21 and APL 22-020. CBAS ERS shall be provided in alternative service locations and/or via Telehealth, including telephone or virtual video conferencing, as clinically appropriate.
- 1) The circumstances for ERS are time-limited and vary based on the unique and identified needs documented in the Member's Individualized Plan of Care (IPC). Contractor must assess Members at least every three (3) months for ERS as part of the reauthorization of the Member's IPC and review for continued need for ERS.
 - 2) Telehealth delivery of ERS must meet HIPAA requirements, and the methodology must be approved by Contractor. Contractor must demonstrate compliance with the Electronic Visit Verification System requirements for personal care services and home health services in accordance with section 12006 of the 21st Century CURES Act and APL 22-014.
 - 3) Contractor shall provide ERS under the following circumstances:
 - a) State or local emergencies as determined by DHCS or Contractor, such as wildfires and power outages, to allow for the provision of ERS prior or subsequent to an official public health emergency declaration as determined by DHCS or Contractor; and
 - b) Personal emergencies, such as time-limited illness or injury, crises, or care transitions that temporarily prevent or restrict Members enrolled in CBAS from receiving CBAS in-person at the CBAS Provider location, subject to approval by Contractor.

3. Coordination of Care

In addition to Exhibit A, Attachment 11, Case Management and External

**Exhibit A, Attachment 19
COMMUNITY BASED ADULT SERVICES (CBAS)**

Coordination of Care, Contractor also agrees to the following:

- A. Contractor shall provide continuity of care to Members through continued access to a CBAS Provider with whom there is an existing relationship for up to 12 months after Member enrollment. This requirement shall include Out-of-Network Providers if there are no quality of care issues and the Provider will accept either Contractor or Medi-Cal FFS rates, whichever is higher, per the continuity of care requirements set forth in Exhibit A, Attachment 9, Access and Availability, Provision 16, Out-of-Network Providers.
- B. Contractor shall ensure that CBAS IPCs are consistent with the Members' overall care plans and goals, based on Person-Centered Planning, and completed in accordance with CalAIM Demonstration STCs, GPR V.A.20., "Individual Plan of Care".
- C. Contractor shall ensure that the initial assessment and reassessment procedures for Members requesting CBAS are done in accordance with the CalAIM Demonstration STCs, GPR VIII.A.48.e., GPR V.A.23.b., and as follows:
 - 1) Within 30 calendar days from the initial eligibility inquiry request, Contractor shall conduct the CBAS eligibility determination using a DHCS-approved assessment tool. CBAS eligibility determinations shall include a face-to-face review with the Member by a Registered Nurse with level of care determination experience for Members who have not previously received CBAS through Contractor's Medi-Cal Managed Care Health Plan. Contractor may forgo a face-to-face review if Contractor has already determined through another process that the Member is clinically eligible for CBAS, and has a need for the start of CBAS to be expedited.
 - 2) Develop and implement an expedited assessment process to determine CBAS eligibility within 72 hours of receipt of a CBAS authorization request for a Member in a hospital or SNF whose discharge plan includes CBAS, or who is at high risk of admission to a SNF, or who faces an imminent and serious threat to their health.
 - 3) Reassessment and redetermination of the Member's eligibility for CBAS is done at least every six (6) months after the initial assessment or up to every 12 months for Members when determined by Contractor to be clinically appropriate. When a Member requests that services remain at the same level or an increase in services due to a change in their level of need, Contractor may conduct the reassessment using only the Member's

**Exhibit A, Attachment 19
COMMUNITY BASED ADULT SERVICES (CBAS)**

IPC, including any supporting documentation supplied by the CBAS Provider.

- 4) Contractor shall not deny, defer, or reduce a requested level of CBAS for a Member without a face-to-face review performed by a Registered Nurse with level of care determination experience and utilizing the assessment tool approved by DHCS.
 - 5) Contractor shall notify Members in writing of the CBAS assessment determination in accordance with the timeframes identified in the CalAIM Demonstration STCs, GPR V.A.23.b.i. Contractor's written notice shall be approved by DHCS and include procedures for Grievances and Appeals in accordance with current requirements identified in Exhibit A, Attachment 14, Member Grievance and Appeal System.
 - 6) Require that CBAS Providers update a Member's CBAS Discharge Plan of Care and provide a copy to the Member and to Contractor whenever a Member's CBAS services are terminated. The CBAS Discharge Plan of Care must include:
 - a) The Member's name and ID number;
 - b) The name(s) of the Member's Physician(s);
 - c) If applicable, the date the Notice of Action denying authorization for CBAS was issued;
 - d) If applicable, the date the CBAS benefit will be terminated;
 - e) Specific information about the Member's current medical condition, treatments, and medications;
 - f) Potential referrals for Medically Necessary services and other services or community resources that the Member may need upon discharge;
 - g) Contact information for the Member's Case Manager; and
 - h) A space for the Member or the Member's representative to sign and date the Discharge Plan of Care.
- D. Contractor shall coordinate Member care with CBAS Providers to ensure the following:
- 1) CBAS IPCs are consistent with Members' overall care plans and goals developed by Contractor.

**Exhibit A, Attachment 19
COMMUNITY BASED ADULT SERVICES (CBAS)**

- 2) Exchange of the following information, conducted in a timely manner to facilitate care coordination: Member discharge plan information; reports of incidents that threaten the welfare, health and safety of the Member; and significant changes in the Member's condition.
 - 3) Clear communication pathways between the appropriate CBAS Provider staff and Contractor personnel responsible for CBAS eligibility determination, authorization, and care planning, including identification of the lead care coordinator for Members who have a care team, and utilization management.
 - 4) Written notification of Contractor's policy and procedure changes, and a process to provide education and training for CBAS Providers regarding any substantive changes that may be implemented, prior to the policy and procedure changes taking effect.
- E. In addition to the requirements for unbundled CBAS contained in Provision 2, and in accordance with Exhibit A, Attachment 11, Provision 3, Out-of-Network Case Management and Coordination of Care, Contractor shall coordinate care for unbundled CBAS that are not Covered Services, based on the assessed needs of the Member eligible for CBAS, including:
- 1) Personal Care Services
 - 2) Social Services
 - 3) Physical and Occupational Maintenance Therapy
 - 4) Meals
 - 5) Specialty Mental Health Services
 - 6) Substance use disorder services that are not Covered Services.

4. Required Reports for the CBAS Program

Contractor shall submit to DHCS the following reports 30 calendar days following the end of the reporting period and in a format specified by DHCS.

- A. Contractor shall report to DHCS on a quarterly basis how many Members have been assessed for CBAS, the total number of Members currently being provided with CBAS, both as a bundled or unbundled service.

**Exhibit A, Attachment 19
COMMUNITY BASED ADULT SERVICES (CBAS)**

- B. In addition to the requirements in Exhibit A, Attachment 6, Provider Network, Provision 11, Provider Network Report, Contractor shall include CBAS Providers added to or deleted from Contractor's Provider Network, and when there is a 5% drop in capacity, within the quarterly Provider Network Report submission.
- C. In addition to the requirements set forth in Exhibit A, Attachment 14, Provision 3, Grievance Log and Grievance Quarterly Reports, Contractor shall also include reports on the following areas:
- 1) Appeals related to requesting CBAS and inability to receive those services or receiving more limited services than requested
 - 2) Appeals related to requesting a particular CBAS Provider and inability to access that Provider
 - 3) Excessive travel times to access CBAS
 - 4) Grievances regarding CBAS Providers
 - 5) Grievances regarding Contractor assessment and/or reassessment.
 - 6) Any reports pertaining to the health and welfare of Members utilizing CBAS.
- D. On an annual basis, Contractor shall provide a list of its contracted CBAS Providers and its CBAS accessibility standards.

5. Community Participation

Contractor must ensure that engagement and community participation for Members receiving CBAS is supported to the fullest extent desired by each Member.

6. CBAS Program Integrity

Following a determination that a credible allegation of fraud exists involving a CBAS Provider, DHCS shall notify Contractor of the finding promptly. In addition to the actions required in APL 15-026, Contractor shall report to DHCS, in a timeframe and manner specified by DHCS but no less frequently than quarterly, all payments made to the CBAS Provider involved in a credible allegation of fraud for CBAS benefits provided after the date of notification. DHCS may recoup payments from Contractor in accordance with CalAIM Demonstration STCs, GPR V.A.30.b.

**Exhibit A, Attachment 20
BEHAVIORAL HEALTH SERVICES**

1. Non-Specialty Mental Health Services (NSMHS) Providers

In addition to Exhibit A, Attachment 6, Provider Network, Provision 1. Network Capacity, Contractor shall also include Non-Specialty Mental Health Services (NSMHS) Providers in its Network in accordance with 42 CFR 438.206, 207, and 208, as applicable. The number of NSMHS Providers shall be adequate to serve Members within its Service Area and provide covered NSMHS benefits. Contractor's NSMHS Providers shall support current and desired service utilization trends for its Members.

- A. Contractor shall increase the number of NSMHS Providers within its Network as necessary to accommodate Enrollment growth. Contractor may contract with any mental health care Provider to provide services within their scope of practice.

- B. The number of NSMHS Providers available shall be sufficient to meet referral and appointment access standards for routine care and shall meet the Timely Access Regulation requirements set forth in Health and Safety Code section 1367.03 and 28 CCR section 1300.67.2.2, in accordance with the requirements set forth in Exhibit A, Attachment 9, Access and Availability, Provision, Access Standards.
 - 1) Contractor may contract with a county mental health plan to ensure access to NSMHS. A Network shall be deemed adequate upon submission and approval of Contractor's boilerplate Subcontractor Agreement or Network Provider Agreement for a county mental health plan.
 - 2) In addition to Exhibit A, Attachment 4, Quality Improvement System, Provision 12, Credentialing and Recredentialing, Contractor shall consider NSMHS Providers as credentialed if the Provider has accreditation from NCQA.
 - 3) In addition to Exhibit A, Attachment 4, Quality Improvement System, Provision 12, Credentialing and Recredentialing, Contractor shall develop and maintain policies and procedures that ensure that the credentials of licensed NSMHS Providers have been verified in accordance with 42 CFR 438.214 and APL 16-012.
 - 4) Any time that a Member requires a Medically Necessary NSMHS that is not available within the Network, Contractor shall ensure access to Out-of-Network Providers and mental health Providers who can provide services via Telehealth as necessary to meet access requirements.
 - 5) Contractor shall develop and implement policies and procedures for the exchange of Member information with the county mental health

**Exhibit A, Attachment 20
BEHAVIORAL HEALTH SERVICES**

plan in order to facilitate referrals and care coordination. The policies and procedures shall cover:

- a) Protected Health Information (PHI) with the county mental health plan for Specialty Mental Health Services, and if separate, the county department responsible for substance use treatment, including Member release of information forms that allow treatment history, active treatment, and health information.
- b) Data sharing agreements with the county mental health plan for Specialty Mental Health Services, and if separate, the county department responsible for substance use treatment, including a Business Associate Agreement that addresses coordination of information related to mental health services and AMSC.
- c) Data tracking of Members receiving Medi-Cal NSMHS.

2. Emergency Services

- A. In addition to the requirements set forth in Exhibit A, Attachment 12, Local Health Department Coordination, Contractor shall have a Memorandum of Understanding (MOU) with the county mental health plan to refer Members in need of urgent and emergency care, including person-to-person telephone transfers, to the county crisis program during their call center hours. The MOU shall be executed in accordance with the requirements specified in Exhibit A, Attachment 10, Scope of Services, and Exhibit A, Attachment 11, Case Management and External Coordination of Care.
- B. In addition to the requirement in the above provision, Contractor shall also ensure a Member access to a first response by their existing mental health Provider during an urgent care situation, when possible. Contractor shall allow the Member's mental health Provider to coordinate care with the county mental health plan or emergency room personnel for urgent care.
- C. Contractor shall develop and implement policies and procedures for the provision of psychiatric emergencies during non-business hours.

3. Provider Network Reports

- A. In addition to the requirements set forth in Exhibit A, Attachment 6, Provider Network, Provision 11, Provider Network Report, the Provider Network report shall identify the number of licensed mental health care Providers. The report shall include:

**Exhibit A, Attachment 20
BEHAVIORAL HEALTH SERVICES**

- 1) Mental health care Provider deletions and additions.
 - 2) The percentage of Providers who deliver services through Telehealth if applicable.
- B. Contractor shall submit monthly reports on NSMHS Providers for the first six (6) months of the implementation of this Amendment, or a new contract, and in a format specified by DHCS. Subsequent reports shall be consistent with the requirements of this Contract.

4. Non-Specialty Mental Health Care Services

- A. NSMHS are those services set forth in the Welfare and Institutions Code, Article 5.9, Section 14189, unless otherwise specifically excluded under the terms of this Contract.
- B. In order to determine whether NSMHS and substance use disorder services are Medically Necessary, Contractor shall apply the criteria of Medical Necessity as stated in APL 17-016 and 17-018.
- C. Contractor shall cover NSMHS and substance use disorder services that are within the scope of practice for licensed mental health care Providers as follows:
- 1) Individual/group mental health evaluation and treatment (psychotherapy);
 - 2) Psychological testing when clinically indicated to evaluate a mental health condition;
 - 3) Outpatient services for the purpose of monitoring drug therapy;
 - 4) Psychiatric consultation;
 - 5) Outpatient laboratory, supplies, and supplements; and
 - 6) AMSC for alcohol use disorders.
- D. Contractor shall cover an initial mental health assessment without requiring Prior Authorization and follow the authorization criteria outlined in Exhibit A, Attachment 5 of this Contract for authorizing additional mental health and substance use disorder services.
- E. Contractor shall develop and implement policies and procedures for mental health services provided by a PCP, including the following services:

**Exhibit A, Attachment 20
BEHAVIORAL HEALTH SERVICES**

- 1) AMSC for alcohol use disorders; and
 - 2) Referrals for additional assessment and treatment.
- F. Contractor shall develop and implement policies and procedures to define and describe what services are to be provided by a PCP or a licensed mental health care Provider. These policies and procedures shall cover the provision of the following services:
- 1) Individual/group mental health evaluation and treatment (psychotherapy);
 - 2) Psychological testing when clinically indicated to evaluate a mental health condition;
 - 3) Outpatient services for the purpose of monitoring drug therapy;
 - 4) Psychiatric consultation, outpatient laboratory, supplies, and supplements; and
 - 5) AMSC for alcohol use disorders.
- G. If a Member becomes eligible for Specialty Mental Health Services during the course of receiving medically necessary NSMHS, Contractor shall continue the provision of non-duplicative, Medically Necessary NSMHS.

5. Alcohol and Substance Use Disorder Treatment Services

Contractor shall ensure the provision of AMSC services by a Member's PCP to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol

6. No Wrong Door for Mental Health Services

Contractor shall implement policy to ensure that Members receive timely mental health services without delay regardless of the delivery system where they seek care, and are able to maintain treatment relationships with trusted Providers without interruption.

- A. Contractor shall provide or arrange for the provision of the following NSMHS:
- 1) Mental health evaluation and treatment, including individual, group, and family psychotherapy.
 - 2) Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition.

**Exhibit A, Attachment 20
BEHAVIORAL HEALTH SERVICES**

- 3) Outpatient services for purposes of monitoring drug therapy.
 - 4) Psychiatric consultation, excluding separately billable psychiatric drugs claimed by outpatient pharmacy providers via Medi-Cal Rx.
 - 5) Outpatient laboratory, drugs, supplies, and supplements.
- B. Contractor shall provide or arrange for the provision of the NSMHS listed above for the following populations after screening:
- 1) Members who are 21 years of age or older with mild to moderate distress, or mild to moderate impairment of mental, emotional, or behavioral functioning resulting from mental health disorders, as defined by the current Diagnostic and Statistical Manual of Mental Disorders;
 - 2) Members who are under 21 years of age, to the extent that they are eligible for services through the EPSDT benefit as described in Exhibit A, Attachment 10, Provision 5.E of this Contract, regardless of the level of distress or impairment, or the presence of a diagnosis; and,
 - 3) Members of any age with potential mental health disorders not yet diagnosed.
- C. Contractor shall cover and pay for emergency room professional services as described in 22 CCR Section 53855.
- D. In accordance with APL 21-014, Contractor shall, in a primary care setting, provide covered substance use disorder (SUD) services, including alcohol and drug screening, assessments, brief interventions, and referral to treatment for Members aged 11 years old and older, including Members who are pregnant. Contractor shall also provide or arrange for the provision of:
- 1) Medications for Addiction Treatment (MAT), also known as medication-assisted treatment, provided in primary care, inpatient hospital, emergency departments, and other contracted medical settings; and
 - 2) Emergency services necessary to stabilize the Member.
- E. Contractor shall implement standardized Screening and Transition of Care Tools for Medi-Cal Mental Health Services in accordance with APLs 22-005 and 22-028. Contractor must update and align policies and

**Exhibit A, Attachment 20
BEHAVIORAL HEALTH SERVICES**

procedures and MOUs with mental health plans to ensure compliance and communicate updates to Providers as necessary.

- 1) In accordance with APL 22-005, Members who are age 21 years old or older shall be screened using the Adult Screening Tool and transitioned using the Adult Transition of Care Tool.
 - 2) In accordance with APL 22-005, Members who are under 21 years of age shall be screened using the Youth Screening Tool and transitioned using the Youth Transition of Care Tool.
- F. Consistent with W&I Code Section 14184.402(f) and APL 22-005, Contractor shall cover clinically appropriate and covered NSMHS prevention, screening, assessment, and treatment services even when:
- 1) Services are provided prior to determination of a diagnosis, during the assessment period, or prior to a determination of whether NSMHS or specialty mental health services (SMHS) access criteria are met;
 - 2) Services are not included in an individual treatment plan;
 - 3) The Member has a co-occurring mental health condition and SUD;
or
 - 4) NSMHS and SMHS services are provided concurrently, if those services are coordinated and not duplicated.

**Exhibit A, Attachment 21
MANAGED LONG-TERM SERVICES AND SUPPORTS**

1. Extent of Requirements

This Attachment and the requirements herein are hereby incorporated in full into the Contract. The requirements included in this Attachment are specific to Full Benefit Dual Eligible Members, Partial Dual Eligible Members, and Medi-Cal Only Members receiving Medi-Cal benefits under the terms of this Contract. Neither Contractor nor DHCS shall interpret any of the requirements in this Attachment to apply to any Member that is not defined as a Full Benefit Dual Eligible Member, Partial Dual Eligible Members, and Medi-Cal Only Members.

2. Provider Network

In addition to Exhibit A, Attachment 6, Provider Network, Contractor also agrees to the following:

- A. Contractor shall ensure that every Long Term Care (LTC) Provider within the Service Area approved by the California Department of Public Health (CDPH) as a qualified Provider is included in their Network, to the extent that the Provider remains licensed, certified, operating, and is willing to enter into a Network Provider Agreement with Contractor on mutually agreeable terms and meets the Contractor's credentialing and quality standards.
- B. If Contractor determines that additional LTC Providers are necessary to meet the needs of its Members, Contractor may extend a contract or letter of agreement to any additional Providers certified by CDPH.
- C. If Contractor determines that Member needs for LTC services exceed Contractor's Network capacity, Contractor shall arrange for access to Out-of-Network Providers in accordance with the requirements of this Contract as stated in Exhibit A, Attachment 9, Access and Availability, Provision 16. Out-of-Network Providers.
- D. In addition to the Network Provider Agreement and Subcontractor Agreement termination requirements in Exhibit A, Attachment 6, Provision 14. Network Provider Agreements and Subcontractor Agreements, and the Member notification requirements in Exhibit A, Attachment 13, Member Services, Provision 5. Notification of Changes in Access to Covered Services, Contractor shall notify DHCS upon termination of an LTC Provider contract:
 - 1) If Contractor and an LTC Provider cannot agree on mutually agreeable terms, Contractor must notify DHCS within five (5) working days of Contractor's decision to exclude the LTC Provider from its Provider Network. DHCS will attempt to resolve the contracting issue when appropriate.

**Exhibit A, Attachment 21
MANAGED LONG-TERM SERVICES AND SUPPORTS**

- 2) Contractor shall provide DHCS with notice of its termination of a contract with an LTC Provider at least 60 days prior to the contract termination effective date.
- 3) If termination of an LTC Provider contract is for a cause related to quality of care or patient safety concerns, Contractor may expedite termination of the LTC Provider contract and transfer Members to an appropriate, contracted LTC facility in an expeditious manner. DHCS shall be notified of the termination within 72 hours of said termination.
- 4) Contractor shall not continue to assign or refer Members to an LTC Provider during the 60 days between notifying DHCS and the contract termination effective date.

3. Provider Relations

In addition to Exhibit A, Attachment 7, Provider Relations, Contractor shall include in regular Provider training key elements of operating a successful program for administering MLTSS, including such topics as the applicable assessment tools and processes, Person-Centered Planning, population specific training and self-direction, information technology, billing, and systems operations.

4. Provider Compensation Arrangements

In addition to Exhibit A, Attachment 8, Provider Compensation Arrangements, Contractor also agrees that Skilled Nursing Facilities and Nursing Facilities (SNF/NF) claims are to be paid in accordance with W&I Code sections 14182.16 and 14186.3.

5. Covered Services

Contractor shall provide MLTSS based on a Member's current assessment, conducted in accordance with the requirements of this Contract, and consistent with Person-Centered Planning. LTC is a Covered Service under this Contract. In addition to Exhibit A, Attachment 10, Scope of Services, Contractor shall also cover Medically Necessary LTC from the time of admission into an appropriate facility to either the Member's release from the facility or to the Member electing to receive hospice services.

- A. Contractor shall ensure that Members in need of LTC are placed in a facility that provides the level of care most appropriate to the Member's medical needs. These health care facilities include SNF/NF, subacute facilities, and Intermediate Care Facilities.
- B. Contractor shall base decisions on the appropriate level of care on the

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definitions set forth in 22 CCR Sections 51118, 51120, 51120.5, 51121, 51124.5, and the criteria for admission set forth in 22 CCR Sections 51335, 51335.5, and 51334 and related sections of the Manual of Criteria for Medi-Cal Authorization referenced in 22 CCR Section 51003(e).

- C. Upon admission to an appropriate facility, Contractor shall assess the Member's health care needs and estimate the potential length of stay of the Member.
- D. Contractor shall provide continuity of care for all Medically Necessary LTC services at non-contracting LTC facilities for those Full Benefit Dual Eligible Members, Partial Dual Eligible Members, and Medi-Cal Only Members residing in an LTC facility at the time of enrollment into Medi-Cal managed care. Contractor shall not require said Members residing in non-contracted facilities to relocate unless it is determined that relocation is Medically Necessary or if the non-contracted LTC facility does not meet the requirements set forth in Provision 8, Paragraph B of this Attachment.

6. Coordination of Care

In addition to Exhibit A, Attachment 11, Case Management and External Coordination of Care, Contractor also agrees to the following:

- A. Contractor shall maintain continuity of care for Members by recognizing any prior treatment authorization made by DHCS for not less than six (6) months following Member enrollment, in accordance with W&I Code Section 14186.3(c)(3).
- B. Contractor shall provide continuity of care to Members through continued access to a CBAS Provider with whom there is an existing relationship for up to 12 months after Member enrollment, or a LTC Provider with whom there is an existing relationship. This requirement shall include Out-of-Network Providers if there are no quality of care issues and the Provider will accept Contractor or Medi-Cal FFS rates, whichever is higher, per the continuity of care requirements set forth in Exhibit A, Attachment 9, Access and Availability, Provision 16. Out-of-Network Providers.
- C. Contractor shall assess risk level and needs for each new Full Benefit Dual Eligible and Partial Dual Eligible Member, as well as current Full Benefit Dual Eligible and Partial Dual Eligible Members upon request, by performing a risk stratification process in accordance with APL 17-012 and, with a particular focus on identifying those Members who may need CBAS, LTC and MSSP.
- D. Contractor shall also assess risk level for each new Medi-Cal Only Member, as well as current Medi-Cal Only Members upon request, by performing a risk stratification process as set forth in APL 17-013 and in

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accordance with APL 17-012.

- E. Contractor shall develop a health risk assessment for Medi-Cal Only Members as set forth in APL 17-013 and in accordance with APL 17-012.
- F. Contractor shall retain and compile a copy of each assessment conducted on behalf of Full Benefit Dual Eligible and Partial Dual Eligible Members through MSSP, CBAS, and/or receiving LTC. Contractor shall review these assessments and determine if any further care coordination of services for the Member is appropriate.
- G. In accordance with W&I Code Section 14182.17(d)(3)(A), Contractor shall not assign a Full Benefit Dual Eligible Member to a PCP, unless it is determined through the risk stratification and assessment process that PCP assignment is necessary in order to properly coordinate the care of the beneficiary or upon the beneficiary's request. The determination to assign a Full Benefit Dual Eligible Member to a PCP shall be done in accordance with APL 14-015.
- H. Contractor shall ensure that coordination of care services for Partial Dual Eligible Members and Medi-Cal Only Members reflect a person-centered, outcome-based approach and shall:
 - 1) Follow the Member's direction about the level of involvement of their caregivers or medical Providers;
 - 2) Coordinate medical care and CBAS, MSSP, IHSS, and LTC with a focus on transitions;
 - 3) Coordinate with county agencies and Providers, if applicable, for necessary and appropriate behavioral health services; and
 - 5) Follow the requirements for Person-Centered Planning set forth for SPD Beneficiaries in this Contract as stated in Exhibit A, Attachment 22, Case Management and Internal Coordination of Care, Provision 32, Person-Centered Planning for Seniors and Persons with Disabilities (SPD) Beneficiaries.
- I. In accordance with applicable State quality assurance and utilization review standards as stated in this Contract, Contractor shall develop an Individual Care Plan (ICP) for newly enrolled and reassessed Medi-Cal Only Members who are high-risk, and shall also review ICPs developed by the MSSP for Full Benefit Dual Eligible Members and Partial Dual Eligible Members to determine if any further coordination or delivery of services is appropriate, pursuant to APL 17-012.
- J. Contractor shall offer an Interdisciplinary Care Team (ICT) to all high-risk

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Medi-Cal Only Members when a need is demonstrated and in accordance with the Member's functional status, assessment, and the ICP. The ICT shall be offered in a manner as specified by DHCS in APL 17-012.

- K. Contractor shall provide coordination of care services or ensure that they are performed by the health plan or contracted Provider care coordinators, in conjunction with the appropriate Network Providers including, but is not limited to Providers for behavioral health, CBAS, MSSP, and LTC.
- L. Contractor shall coordinate referral with timely access to appropriate health care services and community resources through a system that is person and family centered, and allows Members to attain or maintain personal health goals per W&I Code Section 14132.275(f)(7). Contractor shall facilitate a Member's ability to access appropriate community resources and other agencies, including referrals as necessary and appropriate for behavioral services such as mental health and substance use disorders treatment services, and other needed medical or social services outside the managed care health plan's responsibilities in accordance with W&I Code Sections 14182.17(d)(4)(G) and (6)(B).
- M. Contractor shall monitor skilled nursing utilization, and focus on providing services in the least restrictive setting and transitioning between facilities and the community.
- N. Contractor shall coordinate with Medicare Providers as needed in the provision of CBAS, MSSP, or LTC, to the extent that Contractor is able.
- O. DHCS shall authorize Contractor to receive Medicare claims data for any Full Benefit Dual Eligible Members and Partial Dual Eligible Members for the purpose of coordination of care and claims reimbursement.
 - 1) DHCS shall provide the Medicare claims data through its Benefits Coordination and Recovery Center (BCRC).
 - 2) Contractor shall be responsible for any coordination, testing, and implementation activities necessary to ensure that it is able to receive Medicare claims data from BCRC.
 - 3) DHCS shall provide ongoing support through BCRC to aid Contractor in preparing and continuing to receive Medicare claims data.
 - 4) Use of data is limited to the coordination and reimbursement of Med-Cal benefits and services provided to Members and not covered by Medicare in accordance with APL 13-001.
- P. For the purpose of Care Coordination with Members receiving IHSS from the

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county, Contractor shall make best efforts to work with the county and CDSS to share confidential Member data, and to receive Member and Provider data related to the IHSS program when applicable. Data shall be shared and received only as legally authorized by the Member and to promote understanding of the Member's needs.

7. Member Services

- A. In addition to Exhibit A, Attachment 13, Member Services, Provision 4, Written Member Information, Contractor shall include in its provider directory all contracted LTC Network Providers.
- B. In addition to Exhibit A, Attachment 13, Member Services, Provision 7, Primary Care Provider Assignment, Contractor shall use FFS utilization data or other data sources, including electronic data, to establish existing Provider relationships for Partial Dual Eligible Members in order to arrange linkage to a Provider of Medicare outpatient services, should the Member not receive a Primary Care Provider, either through selection or assignment.

8. Required Reports for Managed Long Term Services and Supports

Contractor shall submit to DHCS the following reports:

- A. Contractor shall provide to DHCS a quarterly report on MLTSS. Contractor shall submit these reports in templates provided by DHCS. Templates are subject to revisions; DHCS will communicate updates via email to Contractor.
- B. Contractor shall report to DHCS, on a monthly basis and in a format specified by DHCS, the number of continuity of care requests, and the outcomes of those requests, for Full Benefit Dual Eligible, Partial Dual Eligible, and Medi-Cal Only Members.
- C. In addition to the requirements in Exhibit A, Attachment 6, Provider Network, Provision 11. Provider Network Report, Contractor shall include LTC Providers added to or deleted from Contractor's Provider Network, within the quarterly Provider Network Report submission.
- D. In addition to the requirements set forth in Exhibit A, Attachment 14, Member Grievance and Appeal System, Provision 3. Grievance and Appeal Log and Quarterly Grievance and Appeal Report, Contractor shall also report to DHCS on a monthly basis the number and percentage of Grievances or Appeals that have been submitted in relation to a Member receiving LTC services.
- E. Contractor shall report to DHCS the number of Partial Dual Eligible or

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Medi-Cal Only Members who were assigned to a Primary Care Provider on a monthly basis and in a format specified by DHCS.

9. Risk Corridor

- A. A risk corridor shall be established for a period of 24 months, effective April 1, 2014 and ending on March 31, 2016 for Full Benefit Dual Eligible Members, and applies to the provision of all Covered Services for Full Benefit Dual Eligible Members.
- B. A Risk Corridor shall be established for a period of 24 months, effective July 1, 2014 and ending on June 30, 2016, for Partial Dual Eligible Members and Medi-Cal Only Members, as defined in Exhibit E, Definitions, of this Contract for the applicable period and applies only to the provision of MLTSS, MSSP, and IHSS Covered Services for Partial Dual Eligible Members and Medi-Cal Only Members, as defined in Exhibit E, Definitions, of this Contract for the applicable period.
- C. Gains and losses are defined as the Capitated Revenues minus the sum of Adjusted Service Expenditures for applicable services, as described in Paragraphs A and B of this Provision, and Adjusted Non-Service Expenditures, with positive figures defined as gains and negative figures defined as losses. The risk sharing of the gains and losses shall be constructed by DHCS so that it is symmetrical with respect to risk and profit, and so that all of the following apply:
 - 1) Contractor is fully responsible for any losses up to 1 percent of Capitated Revenues.
 - 2) Contractor shall fully retain any gains up to 1 percent of Capitated Revenues.
 - 3) Contractor and DHCS shall equally share responsibility for any losses in excess of 1 percent, but less than 2.5 percent, of Capitated Revenues.
 - 4) Contractor and DHCS shall equally share any gains greater than 1 percent, but less than 2.5 percent, of Capitated Revenues.
 - 5) DHCS shall be fully responsible for all losses in excess of 2.5 percent of Capitated Revenues.
 - 6) DHCS shall fully retain all gains in excess of 2.5 percent of Capitated Revenues.
- D. The risk-sharing arrangement described in this Provision may result in payment by DHCS to Contractor or by Contractor to DHCS. All payments

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to be made by DHCS to Contractor or by Contractor to DHCS will be calculated and determined by DHCS. All calculations determined by DHCS will be based on Contractor's capitation rate and enrollment data provided by DHCS for applicable Members as described in Paragraphs A and B of this Provision, and Contractor's Adjusted Services Expenditures and Adjusted Non-Service Expenditures for providing applicable services, as described in Paragraphs A and B of this Provision, to these Members.

- 1) All financial reporting will be subject to review and/or audit at DHCS' discretion. As applicable, all calculations will sum Capitated Revenues, Adjusted Services Expenditures and Adjusted Non-Service Expenditures for applicable services as described in Paragraphs A and B of this Provision, across all counties in which Contractor operates as a Medi-Cal Managed Care Health Plan.
- 2) DHCS will determine Contractor's Adjusted Service Expenditures and Adjusted Non-Service Expenditures for applicable services as described in Paragraphs A and B of this Provision, based on Contractor's Actual Services Expenditures and Actual Non-Service Expenditures for these applicable services, Encounter Data, cost data, and financial reporting data, or other data submitted by Contractor either as required in this Contract or by DHCS for the risk-sharing arrangement described in this Provision.
- 3) DHCS and Contractor agree that, to the extent there are differences in Adjusted Services Expenditures and Adjusted Non-Service Expenditures for applicable services as described in Paragraphs A and B of this Provision, and Contractor's Actual Service Expenditures and Actual Non-Service Expenditures for these services across various sources, including the Encounter Data, cost data, financial reporting data, or other data submitted by Contractor, DHCS and Contractor will confer and make a good faith effort to reconcile those differences before the calculation of settlements.
- 4) Review procedures may include a review and/or audit of Contractor's Encounter Data to be performed by DHCS, or either party's authorized agents, to verify that all paid claims for Members by Contractor are for providing services to the population identified in this Provision and/or that Provider reimbursement is not excessive. DHCS will have the final decision on the resolution of any differences in the expenditures.
- 5) DHCS reserves the right to adjust expenditures for services that are reimbursed at more than 10 percent above the median reimbursement rate of all other Contractors within a region.

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- a) For the purposes of this Contract, the region is defined as The Southern Counties Region, which includes Los Angeles, Orange, Riverside, San Bernardino, and San Diego counties.
 - b) If two (2) or fewer counties are operational within a region, experience from other counties would be considered in the establishment of the median rate.
- E. Payments by Contractor to related party Providers shall not exceed the rate paid by Contractor for the same services to unrelated parties within the same county for the purpose of determining actual expenditures. Related parties are defined by Generally Accepted Accounting Principles.

10. Capitation Rate Structure for Full Benefit Dual Eligible Members

A. Underlying Rate Structure

The capitation rate will be paid as a single, blended capitation rate that accounts for the relative risk of Contractor's Full Benefit Dual Eligible Members and is weighted accordingly. These Members shall be segmented into three (3) separate and distinct population segments based on eligibility for rate setting purposes. These population segments are as follows:

- 1) Members eligible for Cal MediConnect, the State's duals demonstration;
- 2) Members covered by Contractor and under Medicare managed care; and
- 3) Members ineligible for Cal MediConnect, such as SPD beneficiaries determined to be high-risk.

B. Full Benefit Dual Eligible Members shall also be grouped into distinct Member mix categories representing differing levels of risk.

- 1) For applicable Rating Periods beginning prior to January 1, 2018, these categories are defined as follows:
 - a) Institutionalized: Members in LTC aid codes and/or residing in an LTC facility for 90 days or more;
 - b) HCBS High: Members identified as high utilizers of HCBS. These Members meet one (1) or more of the following criteria:

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- i) Members who receive CBAS; or
 - ii) Members who are clients of MSSP sites; or
 - iii) Members who receive IHSS and are classified under the IHSS program as “severely impaired”
 - c) HCBS Low: Members identified as low utilizers of HCBS. These Members are IHSS recipients and classified under the IHSS program as “not severely impaired”; and
 - d) Community Well: Members living in the community with no covered HCBS, who are not residents in LTC facilities, and who do not utilize CBAS, MSSP, or IHSS.
- 2) For Rating Periods within the period of January 1, 2018, through December 31, 2021, these categories are defined as follows:
- a) Institutionalized: Members in LTC aid codes and/or residing in an LTC facility for 90 days or more;
 - b) CBAS and MSSP: Members meet one (1) or more of the following criteria:
 - i) Members who receive CBAS; or
 - ii) Members who are clients of MSSP sites
 - c) IHSS Only (no CBAS or MSSP): Members who receive IHSS, but do not receive CBAS and are not clients of a MSSP site; and
 - d) Community Well: Members living in the community with no covered HCBS, who are not residents in LTC facilities, and who do not utilize CBAS, MSSP, or IHSS.
- 3) For the Rating Period effective January 1, 2022, Member mix categories are defined as follows:
- a) Institutionalized: Members in LTC aid codes and/or residing in an LTC facility for 90 days or more;
 - b) CBAS: Members living in the community who utilize CBAS; and

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- c) Other Community: Members living in the community who are not in LTC aid codes, are not residing in a LTC facility for 90 days or more, and do not utilize CBAS.
- C. The capitation rates will utilize the following payment methodology, subject to the phases described in Paragraph D of this Provision:
- 1) DHCS shall pay a blended rate based on the assumed mix across the population segments described in Paragraph A of this Provision and the Member mix categories described in Paragraph B of this Provision.
 - 2) For applicable phases described in Paragraph D of this Provision, DHCS shall recalculate the blended rate based on the actual Full Benefit Dual Eligible Member mix. The final rate based on the actual Member mix will incorporate the same base rates by population segment and Member mix category as the original rate described in Subparagraph 1) of this Paragraph. DHCS shall retain the ability to group Members into the population segments and Member mix categories described in Paragraphs A and B of this Provision.
 - 3) The final blended rate calculations will be completed either monthly, quarterly, or annually as referenced in each respective phase identified in Paragraph D of this Provision.
 - 4) Once DHCS has recalculated the final blended rate, there may be additional payments by DHCS to Contractor or a recoupment of Overpayments from Contractor to DHCS.
- D. The payment process will vary over three (3) distinct phases to address the stability of enrollment and to establish appropriate financial incentives for Contractor.
- 1) Phase I: The recalculation of the final blended rate will be applied monthly and retroactively to match Contractor's actual enrollment. This phase will continue through each county's phase-in enrollment period for a minimum of one (1) year and will end at the start of the following fiscal quarter. For example, if Contractor operates in a county with a 12-month phase-in that began enrollment in April 2014, this phase would last through the end of March 2015.
 - 2) Phase II: This phase will be for one (1) fiscal quarter. The recalculation of the final blended rate will be prospectively applied at the start of the quarter. Weighting of the population segments and Member mix categories will be based on the month preceding the quarter enrollment snapshot, which will be available after the

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quarter ends and will be retroactively applied to that period. For example, if Contractor operates in a county with a 12-month phase-in that begins enrollment in April 2014, this Phase II would be applicable for the fiscal quarter of April 2015 through June 2015. Enrollment data from March 2015 would be utilized although the rate update would not occur until several months after the quarter to ensure data availability.

- 3) Phase III: Contractor's capitation rates are based on a targeted, relative mix of Members and will not be adjusted during the year. The first year of this phase will be the remaining period in the calendar year.
 - a) Specific to Phase III, a targeted, relative mix will be projected by DHCS and its actuaries. This mix is designed to be achievable by Contractor, based on assumptions about Contractor's ability to promote community services and prevent or delay institutional placement.
 - b) If the projected Member mix for Contractor for the year results in a greater than 2.5 percent impact to the Medi-Cal component of the capitation rate paid as compared to the capitation rate that would have been paid based on the actual Member mix, then Contractor and DHCS would share equally in any increases or decreases beyond the 2.5 percent. Contractor's actual gain or loss does not factor into this calculation.
- E. With the structure as described above, DHCS and its actuaries will establish actuarially sound capitation rates for this Contract for Full Benefit Dual Eligible Members eligible for MLTSS. These capitation rates will be consistent with 42 CFR section 438.6(b)(1) and reviewed by the CMS.
- F. Limited risk corridors will be applied as described for Contractor and be reconciled after application of any risk adjustment methodologies and any other adjustments.

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CASE MANAGEMENT AND INTERNAL COORDINATION OF CARE**

1. Comprehensive Case Management Including Coordination of Care Services

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

Contractor must maintain procedures for monitoring the coordination of care provided to Members, including but not limited to all Medically Necessary services delivered both within and outside Contractor's Provider Network. These services are provided through either Basic or Complex Case Management activities based on the medical needs of the Member.

A. Basic Case Management Services are provided by the Primary Care Provider, in collaboration with Contractor, and must include:

- 1) Initial Health Assessment (IHA);
- 2) Individual Health Education Behavioral Assessment (IHEBA);
- 3) Identification of appropriate Providers and Facilities (such as medical, rehabilitation, and support services) to meet Member care needs;
- 4) Direct communication between the Provider and Member/family;
- 5) Member and family education, including healthy lifestyle changes when warranted; and
- 6) Coordination of carved-out and linked services, and referral to appropriate community resources and other agencies.

B. Complex Case Management Services are provided by Contractor, in collaboration with the Primary Care Provider, and must include, at a minimum:

- 1) Basic Case Management Services;
- 2) Management of acute or chronic illness, including emotional and social support issues by a multidisciplinary case management team;
- 3) Intense coordination of resources to ensure Member regains optimal health or improved functionality; and
- 4) With Member and PCP input, development of care plans specific to individual needs, and updating of these plans at least annually.

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- C. Contractor must develop methods to identify Members who may benefit from Complex Case Management services, using utilization data, the HIF/MET, clinical data, and any other available data, as well as self and Physician referrals.

2. Contractor's Responsibilities for Administration of Enhanced Care Management (ECM)

- A. Contractor must take a whole-person approach to offering ECM, ensuring that ECM addresses the clinical and non-clinical needs of high-need and high-cost Members in distinct Populations of Focus, as defined in Provision 3, Populations of Focus for ECM of this Attachment, through systematic coordination of services and Comprehensive Case Management. Contractor must ensure ECM is community-based, interdisciplinary, high-touch, and person-centered.
- B. Contractor must ensure ECM is available throughout its Service Area.
- C. Contractor must ensure ECM is offered primarily through in-person interaction where Members and their family members, guardians, authorized representatives, caregivers, and authorized support persons live, seek care, or prefer to access services in their local community. Contractor must ensure its ECM Providers focus on building relationships with Members, and in-person visits may be supplemented with secure teleconferencing and telehealth, when appropriate and with the Member's consent.
- D. In situations where Contractor is performing ECM functions using Contractor's own staff, Contractor must follow the same requirements as an ECM Provider that is a Network Provider or Subcontractor.
- E. In counties with operating Health Homes Program (HHP) and Whole Person Care (WPC) pilots, Contractor must enter into Subcontractor Agreements or Network Provider Agreements, as appropriate, with WPC Lead Entities and HHP Community-Based Care Management Entities (CB-CMEs) for the provision of ECM, as described in Provision 7, Member Identification for ECM of this Attachment.
- F. Contractor must follow the appropriate processes to ensure Members who may benefit from ECM receive ECM as defined in this Contract.
- G. Contractor must ensure ECM provided to each Member encompasses the ECM core service components described in Provision 12, Core Service Components of ECM of this Attachment.

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- H. Contractor must ensure a Member receiving ECM is not receiving duplicative services from other sources.
- I. For Members who are dually eligible for Medicare and Medi-Cal and enrolled in a Medicare Advantage Plan, including a Dual-Eligible Special Needs Plan (D-SNP), Contractor must coordinate with the Medicare Advantage Plan for the provision of ECM for those Members.
- J. Contractor must develop Member-facing written material about ECM for use across its network of ECM Providers. The written material must be submitted for DHCS review and approval prior to use. This material must include the following:
 - 1) Explain ECM and how a Member may request it;
 - 2) Explain that ECM participation is voluntary and can be discontinued at any time;
 - 3) Explain that the Member must authorize ECM-related data sharing;
 - 4) Describe the process by which the Member may choose a different ECM Lead Care Manager or ECM Provider; and
 - 5) Meet standards for culturally and linguistically appropriate communication outlined in Exhibit A, Attachment 9, Provision 13, Cultural and Linguistic Program and in Exhibit A, Attachment 13, Provision 3, Written Member Information.

3. Populations of Focus for ECM

- A. Subject to the phase-in and Member transition requirements described in Provision 7, Member Identification for ECM of this Attachment.
- B. Contractor must provide ECM to Members that meet the eligibility criteria for at least one (1) of the following Populations of Focus, as described in the ECM Policy Guide:
 - 1) Members over the age of 21 who are:
 - a) Experiencing homelessness;
 - b) High utilizers;
 - c) Experiencing Serious Mental Illness (SMI) or Substance Use Disorder (SUD);

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- d) Transitioning from incarceration;
 - e) At risk for institutionalization who are eligible for Long-Term Care services; or
 - f) Nursing facility residents transitioning to the community.
- 2) Children who are:
- a) Experiencing homelessness;
 - b) High utilizers;
 - c) Experiencing Serious Emotional Disturbance (SED) or identified to be at Clinical High Risk (CHR) for psychosis or experiencing a first episode of psychosis;
 - d) Enrolled in California Children's Services (CCS)/CCS Whole Child Model (WCM) with additional needs beyond the CCS qualifying condition;
 - e) Involved in, or with a history of involvement in, child welfare (including individuals involved in foster care ages 26 and under); or
 - f) Transitioning from incarceration.
- C. Contractor may offer ECM to Members who do not meet Population of Focus criteria in full, but may benefit from ECM.
- D. Contractor must follow all DHCS policies and guidance including All Plan Letters (APLs) and ECM Policy Guide that further defines the approach to ECM for each Population of Focus, including the eligibility criteria for each Population of Focus and the phase-in timeline for Populations of Focus.
- E. To avoid duplication between existing care management and coordination approaches, Members are excluded from ECM while enrolled in the following programs:
- 1) 1915(c) waiver programs including:
 - a) Multipurpose Senior Services Program (MSSP);
 - b) Assisted Living Waiver (ALW);

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- c) Home and Community-Based Alternatives (HCBA) Waiver;
 - d) Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) Waiver;
 - e) HCBS Waiver for Individuals with Developmental Disabilities (DD); and
 - f) Self-Determination Program for Individuals with intellectual and DD.
- 2) Fully integrated programs for Members dually eligible for Medicare and Medi-Cal including:
 - a) Cal MediConnect (CMC);
 - b) Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs); and
 - c) Program for All-Inclusive Care for the Elderly (PACE).
 - 3) Family Mosaic Project
 - 4) California Community Transitions (CCT) Money Follows the Person (MFTP)
 - 5) Basic Case Management (BCM) or Complex Care Management (CCM)

4. ECM Providers

- A. Contractor must ensure ECM is provided primarily through in-person interaction in settings that are most appropriate for the Member, such as where the Member lives, seeks care, or prefers to access services in their local community.
- B. ECM Providers may include, but are not limited to, the following entities:
 - 1) Counties;
 - 2) County behavioral health Providers;
 - 3) Primary Care Physician (PCP), Specialist, or Physician groups;
 - 4) Federally Qualified Health Centers (FQHCs);

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- 5) Community health centers;
 - 6) Community-based organizations;
 - 7) Hospitals or hospital-based Physician groups or clinics (including public hospitals and district or municipal public hospitals);
 - 8) Rural Health Clinics (RHC) and American Indian Health Service (AIHS) Programs;
 - 9) Local Health Departments (LHDs);
 - 10) Behavioral health entities;
 - 11) Community mental health centers;
 - 12) SUD treatment Providers;
 - 13) Community Health Workers;
 - 14) Organizations serving individuals experiencing homelessness;
 - 15) Organizations serving justice-involved individuals;
 - 16) CCS Providers; and
 - 17) Other qualified Providers or entities that are not listed above, as approved by DHCS.
- C. For the Population of Focus for eligible individuals with SMI or SUD and the Population of Focus for eligible individuals with SED, Contractor must prioritize county behavioral health staff or behavioral health Providers to serve in the ECM Provider role, provided they agree and are able to coordinate all services needed by those Populations of Focus, not just their behavioral health services.
- D. Contractor must attempt to enter into a Subcontractor Agreement or Network Provider Agreement, as appropriate, with each AIHS Facility as set forth in 22 CCR sections 55110 through 55180 to provide ECM, when applicable, as described in Exhibit A, Attachment 8, Provision 7, Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), and American Indian Health Service Programs, Paragraph C.
- E. Contractor must ensure ECM Providers meet the requirements set forth in all applicable APLs including, but not limited to, the requirements regarding the use of a care management documentation system.

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- F. Care management documentation systems may include certified electronic health record technology, or other documentation tools that can:
- 1) Document Member goals and goal attainment status;
 - 2) Develop and assign care team tasks;
 - 3) Define and support Member care coordination and care management needs;
 - 4) Gather information from other sources to identify Member needs and support care team coordination and communication; and
 - 5) Support notifications regarding Member health status and transitions in care such as discharges from a hospital or LTC Facility, and housing status.
- G. Contractor must also comply with requirements on data exchange pursuant to Provision 13, Data System Requirements and Data Sharing to Support ECM of this Attachment.
- H. Contractor must ensure all ECM Providers for whom a State-level enrollment pathway exists enroll in Medi-Cal, pursuant to relevant APLs, including APL 19-004. If APL 19-004 does not apply to an ECM Provider, Contractor must have a process for verifying qualifications and experience of ECM Providers, which must extend to individuals employed by or delivering services on behalf of the ECM Provider. Contractor must ensure that all ECM Providers meet the capabilities and standards required to be an ECM Provider.
- I. Contractor must not require eligible ECM Providers to be National Committee for Quality Assurance (NCQA) certified or accredited as a condition of entering into a Subcontractor Agreement or Network Provider Agreement, as appropriate.

5. ECM Provider Capacity

- A. Contractor must develop and manage a network of ECM Providers.
- B. Contractor must ensure sufficient ECM Provider capacity to meet the needs of all ECM Populations of Focus.
- C. Contractor must meet DHCS' requirements regarding ECM Provider capacity separately from general Network adequacy; ECM Provider capacity does not alter the general Network adequacy provisions in Exhibit A, Attachment 6, Provider Network.

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- D. Contractor must report on its ECM Provider capacity to DHCS initially in its ECM MOC Template as referenced in Provision 6, ECM Model of Care (MOC) of this Attachment, and on an ongoing basis pursuant to DHCS reporting requirements in a form and manner specified by DHCS.
- E. Contractor must report to DHCS any significant changes in its ECM Provider capacity as soon as possible but no later than 60 days from the occurrence of the change, in accordance with DHCS reporting requirements in a form and manner specified by DHCS.
- F. If Contractor is unable to provide sufficient capacity to meet the needs of all ECM Populations of Focus through Subcontractor Agreements or Network Provider Agreements, as appropriate, with community-based ECM Providers, Contractor may submit a written request to DHCS for an exception that authorizes Contractor to use Contractor's own personnel for ECM. Any such request must be submitted in accordance with DHCS guidelines and must meet at least one (1) of the following criteria:
 - 1) There are insufficient ECM Providers, or a lack of ECM Providers with qualifications and experience, to provide ECM for one (1) or more of the Populations of Focus in one (1) or more counties;
 - 2) There is a justified quality of care concern with one (1) or more of the otherwise qualified ECM Providers;
 - 3) Contractor and the ECM Providers are unable to agree on rates;
 - 4) ECM Providers are unwilling to contract;
 - 5) ECM Providers are unresponsive to multiple attempts to contract;
 - 6) ECM Providers who have a State-level pathway to Medi-Cal enrollment but are unable to comply with the Medi-Cal enrollment process or Contractor's verification requirements for ECM Providers; or
 - 7) ECM Providers without a State-level pathway to Medi-Cal enrollment that are unable to comply with Contractor's verification requirements for ECM Providers.
- G. During any exception period approved by DHCS, Contractor must take steps to continually develop and increase its ECM Provider network capacity. After expiration of an exception period, Contractor must submit a new exception request to DHCS for DHCS review and approval on a case-by-case basis.

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- H. Contractor's failure to provide network capacity that meets the needs of all ECM Populations of Focus in a community-based manner may result in imposition of corrective action proceedings, and may result in sanctions pursuant to Exhibit E, Attachment 2, Program Terms and Conditions, Provision 16, Sanctions.

6. ECM Model of Care (MOC)

- A. Contractor must develop an ECM Model of Care (MOC) template in accordance with the DHCS-approved ECM MOC template. The ECM MOC must specify Contractor's framework for providing ECM, including a listing of its ECM Providers and policies and procedures for partnering with ECM Providers for the provision of ECM.
- B. In developing and executing Subcontractor Agreements or Network Provider Agreements, as appropriate, with ECM Providers, Contractor must incorporate all requirements and policies and procedures described in its ECM MOC, in addition to all applicable APLs.
- C. Contractor may collaborate with other Medi-Cal Managed Care Health Plans within the same county on the development of its ECM MOC.
- D. Contractor must submit its ECM MOC for DHCS review and approval. Contractor must also submit any significant changes to its ECM MOC for DHCS review and approval at least 60 calendar days in advance of any occurrence of changes or updates, in accordance with DHCS policies and guidance, including all applicable APLs. Significant changes may include, but are not limited to, changes to Contractor's approach to administer or deliver ECM services, approved policies and procedures, and Subcontractor Agreement or Network Provider Agreement boilerplates, as appropriate.

7. Member Identification for ECM

- A. Contractor must promote continuity from the HHP and WPC pilots to ECM.
- B. Contractor must authorize ECM for Members in HHP and WPC pilot counties, following the DHCS implementation schedule.
- C. To ensure continuity between HHP and ECM, Contractor must:
 - 1) Automatically authorize ECM for all Members of ECM Populations of Focus who are enrolled in or are in the process of being enrolled in HHP; and
 - 2) Ensure that each Member automatically authorized for ECM under this Provision is assessed within six (6) months, or other

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timeframes provided by DHCS in guidance for specific transitioning subpopulations, to determine the most appropriate level of services for the Member, to confirm whether ECM or a lower level of care coordination best meets the Member's needs.

- D. To ensure continuity between WPC Pilots and ECM, Contractor must:
- 1) Automatically authorize all Members enrolled in a WPC pilot who are identified by the WPC Lead Entity as belonging to an ECM Population of Focus; and
 - 2) Ensure each Member automatically authorized under this Provision is assessed within six (6) months, or other timeframes provided by DHCS in guidance for specific transitioning subpopulations, to determine the most appropriate level of services for the Member, to confirm whether ECM or a lower level of care coordination best meets the Member's needs.
- E. Contractor must enter into a Subcontractor Agreement or Network Provider Agreement, as appropriate, with each WPC Lead Entity or HHP CB-CME to provide Members with ongoing care coordination previously provided in HHP and WPC pilot counties, except under the permissible exceptions set forth in Paragraph F below.
- F. Contractor must submit to DHCS for prior approval any requests for exceptions to the Subcontractor Agreement or Network Provider Agreement requirement with a WPC Lead Entity or HHP CB-CME as an ECM Provider. Permissible exceptions to the Subcontractor Agreement or Network Provider Agreement requirement, include, but are not limited to:
- 1) There is a justified quality of care concern with the ECM Provider(s);
 - 2) Contractor and ECM Provider(s) are unable to agree on contracted rates;
 - 3) ECM Provider(s) is/are unwilling to contract;
 - 4) ECM Provider(s) is/are unresponsive to multiple attempts to contract;
 - 5) ECM Provider(s) is/are unable to comply with the Medi-Cal enrollment process or vetting by Contractor; or

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- 6) For ECM Provider(s) without a State-level pathway to Medi-Cal enrollment, ECM Provider(s) is/are unable to comply with Contractor processes for vetting qualifications and experience.
- G. Contractor must proactively identify Members who may benefit from ECM and who meet the eligibility criteria for the ECM Populations of Focus, as described in Provision 3, Populations of Focus for ECM of this Attachment.
- H. To identify such Members, Contractor must consider the following:
- 1) Members' health care utilization;
 - 2) Needs across physical, behavioral, developmental, and oral health;
 - 3) Health risks and needs due to Social Drivers of Health; and,
 - 4) Long-term services and supports (LTSS) needs.
- I. Contractor must identify Members for ECM through the following pathways:
- 1) Analysis of Contractor's own Enrollment, claims, and other relevant data and available information. Contractor must use data analytics to identify Members who may benefit from ECM and who meet the criteria for the ECM Populations of Focus. Contractor must consider data sources, including but not limited to:
 - a) Enrollment data;
 - b) Encounter Data;
 - c) Utilization/claims data;
 - d) Pharmacy data;
 - e) Laboratory data;
 - f) Screening or assessment data;
 - g) Clinical information on physical and behavioral health;
 - h) SMI/SED/SUD data, if available;
 - i) Information about Social Drivers of Health, including standardized assessment tools including Protocol for Responding to and Assessing Patients' Assets, Risks and

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Experiences (PRAPARE) and International Classification of Diseases, Tenth Revision (ICD-10) codes;

- j) Results from any available Adverse Childhood Experience (ACE) screening; and
 - k) Other cross-sector data and information, including housing, social services, foster care, criminal justice history, and other information relevant to the ECM Populations of Focus such as Homeless Management Information System (HMIS), and available data from the education system.
- 2) Receipt of requests from ECM Providers and other Providers or community-based entities.
- a) Contractor must accept requests for ECM on behalf of Members from:
 - i. ECM Providers;
 - ii. Social service or other Providers; and
 - iii. Community-based entities, including those contracted to provide Community Supports, as described in Provision 20, Community Supports Providers of this Attachment.
 - b) Contractor must designate an email and dedicated phone number that is widely available by which referrals can be made.
 - c) Contractor must directly engage with Network Providers, Subcontractors, and county agencies to inform these entities of ECM, the ECM Populations of Focus, and how to request ECM for Members.
 - d) Contractor must encourage ECM Providers to identify Members who meet the criteria for the ECM Populations of Focus, and must develop a process for receiving and responding to requests from ECM Providers.
- 3) Requests from Members.

Contractor must have a process for allowing Members to request ECM and for Members' parents, family members, legal guardians, authorized representatives, caregivers, and authorized support persons to request ECM on a Member's behalf. Contractor must

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provide information to Members regarding the Member initiated ECM request and approval process.

8. Authorizing Members for ECM

- A. Contractor must authorize ECM for each eligible Member identified through any of the pathways described in Provision 7, Member Identification for ECM of this Attachment.
- B. Contractor must develop policies and procedures that explain how it will authorize ECM for eligible Members in an equitable and non-discriminatory manner.
- C. For requests from Providers and other external entities, Members, Member's parent, family member, legal guardian, authorized representative, caregiver, or authorized support person:
 - 1) Contractor must ensure that authorization or a decision to not authorize ECM occurs as soon as possible and in accordance with Exhibit A, Attachment 5, Provision 3, Timeframes for Medical Authorization and APL 21-011;
 - 2) If Contractor does not authorize ECM, Contractor must ensure the Member and the requesting individual or entity who requested ECM on a Member's behalf, as applicable, are informed of the Member's right to an Appeal and the Appeals process by way of the Notice of Action (NOA) as described in Exhibit A, Attachment 13, Provision 8, Denial, Deferral, or Modification of Prior Authorization Requests, Exhibit A, Attachment 14, Member Grievance and Appeal System, and APL 21-011; and
 - 3) Contractor must follow its standard Grievances and Appeals process outlined in Exhibit A, Attachment 14, Member Grievance and Appeal System and APL 21-011.
- D. Contractor must follow requirements for transitioning Members previously served by WPC pilots or HHP contained in Provision 7, Member Identification for ECM of this Attachment.
- E. Contractor may collaborate with its ECM Providers to develop a process and identify possible circumstances under which presumptive authorization or preauthorization of ECM may occur, where select ECM Providers may directly authorize ECM for a limited period of time until Contractor authorizes or denies ECM.
- F. To inform Members that ECM has been authorized, Contractor must follow its standard notice process outlined in Exhibit A, Attachment 13, Provision

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8, Denial, Deferral, or Modification of Prior Authorization Requests and APL 21-011.

9. Assignment to an ECM Provider

- A. Contractor must assign every Member authorized for ECM to an ECM Provider. Contractor may assign Members to Contractor itself only with a DHCS-approved exception to the ECM Provider contracting requirement as described in Provision 5, ECM Provider Capacity, of this Attachment.
- B. Contractor must develop a process to disseminate information of assigned Members to ECM Providers on a regular basis.
- C. Contractor must ensure communication of Member assignment to the designated ECM Provider occurs within ten (10) Working Days of authorization or on an agreed upon schedule.
- D. If a Member prefers a specific ECM Provider, Contractor must assign the Member to that ECM Provider, to the extent practicable.
- E. If a Member's assigned PCP is a Network Provider and an ECM Provider, Contractor must assign the Member to the PCP as the ECM Provider, unless the Member indicates otherwise or Contractor identifies a more appropriate ECM Provider given the Member's individual needs and health conditions.
- F. If a Member receives services from a behavioral health Provider for SED, SUD, or SMI and the Member's behavioral health Provider is a Network Provider and an ECM Provider, Contractor must assign that Member to that behavioral health Provider as the ECM Provider, unless the Member indicates otherwise or Contractor identifies a more appropriate ECM Provider given the Member's individual needs and health conditions.
- G. If a Member is enrolled in CCS and the Member's CCS Case Manager is affiliated with a Network Provider or Subcontractor that is also an ECM Provider, Contractor must assign that Member to the CCS Case Manager as the ECM Provider, unless the Member or parent, legal guardian, or authorized representative has indicated otherwise or Contractor identifies a more appropriate ECM Provider given the Member's individual needs and health conditions.
- H. Contractor must notify the Member's PCP, if different from the ECM Provider, of the assignment to the ECM Provider, within ten (10) Working Days of the date of assignment.

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- I. Contractor must document the Member's ECM Lead Care Manager in its system of record.
- J. Contractor must permit Members to change ECM Providers at any time. Contractor must implement any Member's request to change their ECM Provider within 30 calendar days, to the extent practicable.

10. Initiating Delivery of ECM

- A. Contractor must not require Member authorization for ECM-related data sharing (whether in writing or otherwise) as a condition of initiating delivery of ECM, unless such authorization is required by federal law.
- B. Contractor must develop policies and procedures for its network of ECM Providers that meet the following requirements, including but not limited to:
 - 1) Where required by law, ECM Providers must obtain Member's authorization to share information with Contractor and all others involved in the Member's care to maximize the benefits of ECM; and
 - 2) ECM Providers must provide Contractor with Member-level records of any obtained authorizations for ECM-related data sharing as required by federal law and to facilitate ongoing data sharing with Contractor.
- C. Contractor must ensure that upon the initiation of ECM, each Member receiving ECM has a Lead Care Manager with responsibility for interacting directly with the Member and the Member's family, legal guardians, authorized representatives, caregivers, and other authorized support persons, as appropriate.

The assigned ECM Lead Care Manager is responsible for engaging with a multi-disciplinary care team to identify gaps in Member's care and, at a minimum, ensure effective coordination of all physical health care, behavioral, developmental, oral health, LTSS, Community Supports, and other services to address Social Drivers of Health, regardless of setting.

- D. Contractor must ensure accurate and up-to-date Member-level records related to the provision of ECM services are maintained for Members authorized for ECM.

11. Discontinuation of ECM

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- A. Contractor must ensure Members are able to decline or end ECM upon initial outreach and engagement, or at any other time.
- B. Contractor must require the ECM Provider to notify Contractor to discontinue ECM for Members when any of the following circumstances are met:
 - 1) The Member has met all care plan goals;
 - 2) The Member is ready to transition to a lower level of care;
 - 3) The Member no longer wishes to receive ECM or is unresponsive or unwilling to engage; or
 - 4) The ECM Provider has not been able to connect with the Member after multiple attempts.
- C. Contractor must develop processes to determine if the Member is no longer authorized to receive ECM and, if so, to notify ECM Provider to initiate discontinuation of services in accordance with the NOA process as described in Exhibit A, Attachment 13, Provision 8, Denial, Deferral, or Modification of Prior Authorization Requests; Exhibit A, Attachment 14, Member Grievance and Appeal System; and APL 21-011.
- D. Contractor must develop processes for transitioning Members from ECM to lower levels of care management to provide coordination of ongoing needs.
- E. Contractor must notify the ECM Provider when ECM has been discontinued by Contractor.
- F. Contractor must notify the Member of the discontinuation of the ECM benefit and ensure the Member is informed of their right to an Appeal and the Appeals process by way of a NOA process as described in Exhibit A, Attachment 13, Provision 8, Denial, Deferral, or Modification of Prior Authorization Requests, Exhibit A, Attachment 14, Member Grievance and Appeal System, and APL 21-011.

12. Core Service Components of ECM

Contractor must ensure all Members receiving ECM benefits receive all of the following seven (7) ECM core service components, as further defined in applicable APLs:

- A. Outreach and engagement
- B. Comprehensive assessment and care management plan;

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- C. Enhanced coordination of care;
- D. Health promotion;
- E. Comprehensive transitional care;
- F. Member and family supports; and
- G. Coordination of and referral to community and social support services.

13. Data System Requirements and Data Sharing to Support ECM

- A. Contractor must have an IT infrastructure and data analytic capabilities to support ECM, including the capabilities to:
 - 1) Consume and use claims and Encounter Data, as well as other data types listed in Provision 7, Member Identification for ECM, of this Attachment;
 - 2) Assign Members to ECM Providers;
 - 3) Keep records of Members receiving ECM and authorizations necessary for sharing Protected Health Information and Personal Identifying Information between Contractor and ECM Providers and other Providers, and among ECM Providers and family member(s) or support person(s), whether obtained by ECM Provider or by Contractor;
 - 4) Securely share data with ECM Providers and other Providers in support of ECM;
 - 5) Receive, process, and send Encounter Data from ECM Providers to DHCS;
 - 6) Receive and process supplemental reports from ECM Providers;
 - 7) Send ECM supplemental reports to DHCS; and
 - 8) Open, track, and manage referrals to Community Supports Providers.
- B. In order to support ECM, Contractor must follow DHCS guidance on data sharing and provide the following information to all ECM Providers:
 - 1) Member assignment files, defined as a list of Medi-Cal Members authorized for ECM and assigned to the ECM Provider;

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- 2) Encounter Data and claims data;
 - 3) Physical, behavioral, administrative, and Social Drivers of Health data, such as HMIS data, for all Members assigned to the ECM Provider; and
 - 4) Reports of performance on quality measures and metrics, as requested.
- C. Contractor must use defined federal and State standards, specifications, code sets, and terminologies when sharing physical, behavioral, social, and administrative data with ECM Providers and with DHCS.

14. Oversight of ECM Providers

- A. Contractor must perform oversight of ECM Providers, holding them accountable to all ECM requirements contained in this Contract, DHCS policies and guidance, including all applicable APLs, and Contractor's ECM MOC.
- 1) Contractor must evaluate the prospective Subcontractor's or Network Provider's ability to perform services;
 - 2) Contractor must ensure the Subcontractor's or Network Provider's ECM Provider capacity is sufficient to serve all Populations of Focus;
 - 3) Contractor must report to DHCS the names of all Subcontractors or Network Providers, as appropriate, by type and service(s) provided, and identify the county or counties in which Members are served; and
 - 4) Contractor must make all Subcontractor Agreements or Network Provider Agreements, as appropriate, available to DHCS upon request. Such agreements must contain minimum required information specified by DHCS, including method and amount of compensation as described in Exhibit A, Attachment 6, Provision 14, Network Provider Agreements and Subcontractor Agreements.

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- B. Contractor must hold ECM Providers responsible for the same reporting requirements as those Contractor has with DHCS.
 - 1) Contractor must not impose mandatory reporting requirements that differ from or are additional to those required for Encounter and supplemental reporting; and
 - 2) Contractor may collaborate with other Medi-Cal Managed Care Health Plans within the same county on oversight of ECM Providers.
- C. Contractor must not utilize tools developed or promulgated by NCQA to perform oversight of ECM Providers, unless by mutual consent with the ECM Provider.
- D. Contractor must provide ECM training and technical assistance to ECM Providers, including in-person sessions, webinars, or calls, as necessary, in addition to Network Provider training requirements, as applicable, described in Exhibit A, Attachment 7, Provision 5, Network Provider Training.
- E. Contractor must ensure Subcontractor Agreements and Network Provider Agreements, as appropriate, mirror the requirements set forth in this Contract and in accordance with all applicable APLs, as applicable to the Subcontractor or Network Provider.

Contractor may collaborate with its Subcontractors or Network Providers, as appropriate, on the approach to administration of ECM to minimize divergence in how ECM will be implemented between Contractor and its Subcontractors or Network Providers, and to ensure a streamlined, seamless experience for ECM Providers and Members.

15. Payment of ECM Providers

- A. Contractor must pay ECM Providers for the provision of ECM in accordance with Subcontractor Agreements or Network Provider Agreements established between Contractor and each ECM Provider.
- B. Contractor must ensure that ECM Providers are eligible to receive payment when ECM is initiated for any given Member, as defined in Provision 10, Initiating Delivery of ECM, of this Attachment.

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- C. Contractor may tie ECM Provider payments to value, including payment strategies and arrangements that focus on achieving outcomes related to high-quality care and improved health status.
- D. Contractor must utilize the claims timeframes as described in Exhibit A, Attachment 8, Provision 5, Claims Processing.

16. DHCS Oversight of ECM

- A. Contractor must submit the following data and reports to DHCS to support DHCS oversight of ECM:
 - 1) Encounter Data
 - a) Contractor must submit all ECM Encounter Data to DHCS using national standard specifications and code sets to be defined by DHCS.
 - b) Contractor shall be responsible for submitting to DHCS all Encounter Data for ECM services to its Members, regardless of the number of levels of delegation or sub-delegation between Contractor and the ECM Provider.
 - c) In the event the ECM Provider is unable to submit ECM Encounter Data to Contractor using the national standard specifications and code sets to be defined by DHCS, Contractor is responsible for converting the ECM Provider's Encounter Data information into the national standard specifications and code sets, for submission to DHCS.
 - 2) ECM supplemental reports, on a schedule and in a format to be defined by DHCS.
- B. Contractor must track and report to DHCS, on a schedule and in a format specified by DHCS, information about outreach efforts related to Members who could potentially be enrolled in ECM.
- C. In the event of underperformance by Contractor in relation to its administration of ECM, DHCS may impose sanctions as described in Exhibit E, Attachment 2, Provision 17, Sanctions.

17. ECM Quality and Performance Incentive Program

- A. Contractor must meet all quality management and quality improvement requirements in Exhibit A, Attachment 4, Quality Improvement System,

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and any additional quality requirements set forth in associated guidance from DHCS for ECM.

- B. Contractor may participate in a performance incentive program related to building provider capacity for ECM, related health care quality and outcomes, and other performance milestones and measures, in accordance with APL 21-016 or other technical guidance.

18. Contractor's Responsibility for Administration of Community Supports

- A. Contractor may provide DHCS pre-approved Community Supports as described in Provision 19, DHCS Pre-Approved Community Supports, of this Attachment.

The remainder of Exhibit A, Attachment 22 refers only to Community Supports that Contractor may choose to offer, unless otherwise specified.

- B. In accordance with 42 CFR section 438.3(e)(2), all applicable APLs, and the Community Supports Policy Guide, Contractor may select and offer Community Supports from the list of Community Supports pre-approved by DHCS as medically appropriate and cost-effective substitutes for Covered Services or settings under the State Plan. See Provision 19, DHCS Pre-Approved Community Supports below for list.
 - 1) Contractor must ensure medically appropriate State Plan services are available to the Member regardless of whether the Member has been offered Community Supports, is currently receiving Community Supports, or has received Community Supports in the past.
 - 2) Contractor may not require a Member to utilize Community Supports. Members always retain their right to receive the California Medicaid State Plan Covered Services on the same terms as would apply if Community Supports was not an option in accordance with regulatory requirements.
 - 3) Contractor must not use Community Supports to reduce, discourage, or jeopardize Members' access to State Plan services.
 - 4) Contractor may submit a request to DHCS to offer Community Supports in addition to the pre-approved Community Supports.
- C. With respect to pre-approved Community Supports, Contractor must adhere to DHCS' guidance on service definitions, eligible populations, code sets, potential Community Supports Providers, and parameters for each Community Support, referenced in APL 21-017 and the Community Supports Policy Guide, that Contractor chooses to provide. Upon approval

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from DHCS, Contractor may adopt a more narrowly defined eligible population than outlined in the Community Supports Policy Guide.

- 1) Contractor is not permitted to extend Community Supports to Members beyond those for whom DHCS has determined the Community Supports will be cost-effective and medically appropriate, as indicated in the DHCS guidance on eligible populations.
 - 2) Contractor must provide public notice of any limitations on Community Supports when Contractor requests an alternate approach involving narrowing eligible populations, including specifying such limitations in the Member Services Guide/EOC and on Contractor's website, in addition to receiving DHCS' written approval.
- D. If Contractor elects to offer one (1) or more pre-approved Community Supports, it need not offer the Community Supports in each county it serves. Contractor must report to DHCS the counties in which it intends to offer the Community Supports. Contractor must provide Community Supports in a county selected by Contractor in accordance with the requirements set forth below in Provision 21, Community Supports Provider Capacity.
- E. Contractor must identify Members who may benefit from Community Supports and for whom Community Supports will be a medically appropriate and cost-effective substitute for Covered Services, and accept requests for Community Supports from Members and Members' Providers and organizations that serve them, including community-based organizations as described below in Provision 23, Identifying Members for Community Supports.
- F. Contractor must authorize Community Supports for Members deemed eligible in accordance below with Provision 24, Authorizing Members for Community Supports and Communication of Authorization Status.
- G. Contractor may elect to offer value-added services in addition to offering one (1) or more Community Supports. Offering Community Supports does not preclude Contractor from offering value-added services.
- H. In the event of any discontinuation of Community Supports resulting in a change in the availability of services, Contractor must adhere to the requirements set forth in Exhibit A, Attachment 9, Provision 10, Changes in Availability or Location of Covered Services, and Exhibit A, Attachment 13, Provision 4, Notification of Changes in Access to Covered Services.
- I. When Members are dually eligible for Medicare and Medi-Cal, and

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enrolled in a Medicare Advantage Plan, including a D-SNP, Contractor must coordinate with the Medicare Advantage Plan in the provision of Community Supports.

J. Contractor must not require Members to use Community Supports.

19. DHCS Pre-Approved Community Supports

A. Contractor may choose to offer Members one (1) or more of the following pre-approved Community Supports, and any subsequent Community Supports additions pre-approved by DHCS, in each county:

- 1) Housing Transition Navigation Services;
- 2) Housing Deposits;
- 3) Housing Tenancy and Sustaining Services;
- 4) Short-Term Post-Hospitalization Housing;
- 5) Recuperative Care (Medical Respite);
- 6) Respite Services;
- 7) Day Habilitation Programs;
- 8) Nursing Facility Transition/Diversion to Assisted Living Facilities;
- 9) Community Transition Services/Nursing Facility Transition to a Home;
- 10) Personal Care and Homemaker Services;
- 11) Environmental Accessibility Adaptations;
- 12) Medically Tailored Meals/Medically Supportive Food;
- 13) Sobering Centers; and
- 14) Asthma Remediation.

B. Contractor must list all Community Supports it offers in its Contractor's Community Supports MOC template and Community Supports MOC amendments.

C. Contractor must ensure Community Supports are provided in accordance with all applicable APLs, unless DHCS has provided written approval of an

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alternate approach requested by Contractor.

- D. Contractor must ensure Community Supports are provided to Members in a timely manner, and must develop policies and procedures outlining its approach to managing Community Supports Provider shortages or other barriers to ensure timely provision of Community Supports.
- E. Contractor may discontinue offering Community Supports annually with notice to DHCS at least 90 calendar days prior to the discontinuation date.

Contractor must ensure Community Supports that were authorized for a Member prior to the discontinuation of those specific Community Supports are not disrupted by a change in Community Supports offerings, either by completing the authorized service or by seamlessly transitioning the Member into other Medically Necessary services or programs that meet the Member's needs.

- F. At least 30 calendar days before withdrawal of one (1) or more Community Supports that it offers, Contractor must notify Members impacted of the following:
 - 1) The change and timing of withdrawal, and
 - 2) The procedures that will be used to ensure completion of the authorized Community Supports or a transition into other comparable Medically Necessary services.
- G. Contractor may provide voluntary services that are neither State-approved Community Supports nor Covered Services when medically appropriate for the Member, in accordance with 42 CFR section 438.3(e)(1). Such voluntary services are not subject to the terms of Provision 18, Contractor's Responsibility for Administration of Community Supports, through Provision 31, Community Supports Quality and Performance Incentive Program, and are subject to the limitations of 42 CFR section 438.3(e)(1).

20. Community Supports Providers

- A. Community Supports Providers are entities that Contractor has determined can provide the Community Supports to eligible Members in an effective manner consistent with culturally and linguistically appropriate care, as outlined in Exhibit A, Attachment 9, Provision 13, Cultural and Linguistic Program.
- B. Contractor must enter into Subcontractor Agreements or Network Provider Agreements, as appropriate, with Community Supports Providers for the delivery of elected Community Supports elected by Contractor.

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- C. Contractor must ensure all Community Supports Providers for whom a State-level enrollment pathway exists enroll in Medi-Cal, pursuant to relevant APLs, including APL 19-004. If APL 19-004 does not apply to a Community Supports Provider, Contractor must have a process for verifying qualifications and experience of Community Supports Providers, which must extend to individuals employed by or delivering services on behalf of the Community Supports Provider. Contractor must ensure that all Community Supports Providers meet the capabilities and standards required to be a Community Supports Provider.
- D. In accordance with Provision 26 below, Data System Requirements and Data Sharing to Support Community Supports, Contractor must support Community Supports Provider access to systems and processes allowing them to do the following, at a minimum:
 - 1) Obtain and document Member information including eligibility, Community Supports authorization status, Member authorization for data sharing to the extent required by law, and other relevant demographic and administrative information; and
 - 2) Contractor must also support Community Supports Provider notification to Contractor and ECM Providers and Member's PCP, as applicable, when a referral has been fulfilled, as described below in Provision 26, Data System Requirements and Data Sharing to Support Community Supports.
- E. To the extent Contractor elects to offer Community Supports, Contractor may coordinate its approach with other Medi-Cal Managed Care Health Plans offering Community Supports in the same county.

21. Community Supports Provider Capacity

- A. Contractor must develop a robust network of Community Supports Providers to deliver all elected Community Supports.
- B. If Contractor is unable to offer its elected Community Supports to all eligible Members for whom it is medically appropriate and cost-effective within a particular county, Contractor must submit ongoing progress reports to DHCS in a format and manner specified by DHCS.
- C. Contractor must ensure its Network Provider and Subcontractor Community Supports Providers have sufficient capacity to receive referrals for Community Supports and provide the agreed-upon volume of Community Supports to Members who are authorized for such services on an ongoing basis.

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22. Community Supports MOC

- A. Contractor must develop a Community Supports MOC in accordance with the DHCS-approved Community Supports MOC template. The Community Supports MOC must specify Contractor's framework for providing Community Supports, including a listing of its Community Supports Providers and policies and procedures for partnering with Community Supports Providers for the provision of Community Supports.
- B. In developing and executing Subcontractor Agreements or Network Provider Agreements, as appropriate, with Community Supports Providers, Contractor must incorporate all requirements and policies and procedures described in its Community Supports MOC, in addition to all applicable APLs.
- C. Contractor may collaborate with other Medi-Cal Managed Care Health Plans within the same county, on the development of its Community Supports MOC.
- D. Contractor must submit its Community Supports MOC for DHCS review and approval. Contractor must submit to DHCS any substantial changes to its Community Supports MOC for DHCS review and approval at least 60 calendar days in advance of any occurrence of changes or updates, in accordance with DHCS policies and guidance, including all applicable APLs. Substantial changes may include, but are not limited to, changes to Contractor's approach to administer or deliver Community Supports services, approved policies and procedures, and Subcontractor Agreement or Network Provider Agreement boilerplates, as appropriate.

23. Identifying Members for Community Supports

- A. Contractor must utilize a variety of methods to identify Members who may benefit from Community Supports, in accordance with all applicable APLs.
- B. Contractor must develop policies and procedures for Community Supports, and submit its policies and procedures to DHCS for review and approval prior to its implementation. Contractor's policies and procedures must address the following, at a minimum:
 - 1) How Contractor will identify Members eligible for Community Supports;
 - 2) How Contractor will notify Members; and
 - 3) How Contractor will receive requests to evaluate Members for Community Supports from Providers, community-based entities,

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Members or Members' families, legal guardians, authorized representatives, and caregivers.

- C. Contractor must submit all Member notices to DHCS for review and approval prior to implementation.
- D. Contractor must ensure that Member identification methods for Community Supports are equitable and do not exacerbate or contribute to existing racial and ethnic disparities.
- E. Transition of WPC and HHP to Community Supports
 - 1) In HHP and WPC pilot counties, Contractor may offer Community Supports to HHP and WPC Members who receive similar services through WPC or HHP for continuity of the services being delivered as part of those programs.
 - 2) In HHP and WPC pilot counties, Contractor must enter into Subcontractor Agreements or Network Provider Agreements, as appropriate, with all WPC Lead Entities and HHP CB-CMEs as Community Supports Providers, regardless of whether Contractor offers Community Supports on a county-wide basis, unless Contractor receives prior written approval from DHCS, through the Community Supports MOC review process, based on one (1) or more of the following exceptions:
 - a) The Community Supports Provider does not provide the Community Supports that Contractor elected to offer;
 - b) There is a justified quality of care concern with the Community Supports Provider;
 - c) Contractor and the Community Supports Provider are unable to agree on contracted rates;
 - d) The Community Supports Provider is unwilling to enter into a Subcontractor Agreement or Network Provider Agreement, as appropriate;
 - e) The Community Supports Provider is unresponsive to multiple attempts to enter into a Subcontractor Agreement or Network Provider Agreement, as appropriate;
 - f) The Community Supports Provider is unable to comply with the Medi-Cal enrollment process or vetting by Contractor; or
 - g) The Community Supports Provider without a State-level

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pathway to Medi-Cal enrollment is unable to comply with Contractor's processes for vetting qualifications and experience.

24. Authorizing Members for Community Supports and Communication of Authorization Status

- A. Contractor must develop policies and procedures that explain how Contractor will authorize Community Supports for eligible Members in an equitable and non-discriminatory manner. Contractor's policies and procedures must be submitted to DHCS for review and approval prior to implementation.
- B. Contractor must monitor and evaluate Community Supports authorizations to ensure they are equitable and non-discriminatory. Contractor must have policies and procedures in place for immediate actions that will be undertaken if monitoring/evaluation processes reveal that service authorizations have had an inequitable effect.
- C. For Members with an assessed risk of incurring other California Medicaid State Plan services, such as inpatient hospitalizations, skilled nursing facility stays, or emergency department visits, Contractor must develop policies and procedures to ensure appropriate clinical support authorization of Community Supports for Members. Contractor's policies and procedures must include detailed documentation that a Network Provider using their professional judgement has determined it to be medically appropriate for the Member to receive Community Supports as it is likely to reduce or prevent the need for acute care or other California Medicaid State Plan services in accordance with all applicable APLs and to be defined in forthcoming guidance.
- D. Contractor must not restrict the authorization of Community Supports only to Members transitioning from WPC or HHP.
- E. Contractor must develop and maintain policies and procedures to ensure Members do not experience undue delays pending the authorization process for Community Supports.
 - 1) If Medically Necessary, Contractor must make available the California Medicaid State Plan services that the Community Supports replaces, pending authorization of the requested Community Supports.
 - 2) Contractor must evaluate and document whether a service is medically appropriate and cost-effective when determining whether to provide Community Supports to a Member. Providing particular Community Supports to a Member in one (1) instance does not

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automatically mean that providing other Community Supports to the same Member, the same Community Supports to another Member, or the same Community Supports to the same Member in a different instance would be medically appropriate and cost-effective.

- F. Contractor must have policies and procedures for expediting the authorization of certain Community Supports for urgent needs, as appropriate, and that identify the circumstances in which any expedited authorization processes apply, in accordance with all applicable APLs.
- G. When a Member has requested Community Supports, directly or through a Provider, Contractor must notify the requestor and Member of Contractor's decision regarding Community Supports authorization, in accordance with all applicable APLs, and State and federal privacy laws and regulations. If Contractor receives a request to evaluate a Member for Community Supports from an individual or organization who is not an authorized representative of the Member, Contractor must obtain Member's consent prior to sharing information on Contractor's decision regarding Community Supports authorization. If Contractor is not able to obtain Member's consent to share information, Contractor may not share the Member's personal information with the requestor. If the Member is enrolled in ECM, Contractor must ensure the ECM Provider is informed of the Community Supports authorization decision.
- H. Member always retains the right to file Appeals and/or Grievances if they request one (1) or more Community Supports offered by Contractor, but were not authorized to receive the requested Community Supports because of a determination that it was not medically appropriate or cost effective.
- I. For Members who sought Community Supports offered by Contractor, but were not authorized to receive the Community Supports, Contractor must submit necessary data to monitor Appeals and Grievances as well as follow its standard Grievances and Appeals process outlined in Exhibit A, Attachment 14, Member Grievance and Appeal System and APL 21-011.

25. Referring Members to Community Supports Providers for Community Supports

- A. Contractor must develop and maintain policies and procedures to define how Community Supports Provider referrals will occur. Contractor's policies and procedures must be submitted to DHCS for review and approval prior to implementation.
 - 1) For Members enrolled in ECM, policies and procedures must address how Contractor will work with the ECM Provider to

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coordinate the Community Supports referral and communicate the outcome of the referral back to the ECM Provider, such as using closed loop referrals.

- 2) Contractor's policies and procedures must include expectations and procedures to ensure referrals occur in a timely manner after service authorization.
- B. If the Member prefers a particular Community Supports Provider and Contractor is aware of this preference, Contractor must follow those preferences, to the extent practicable.
- C. Contractor must track referrals to Community Supports Providers to verify if the authorized service has been delivered to the Member.

If the Member receiving the Community Support is also receiving ECM, Contractor must monitor to ensure that the ECM Provider tracks whether the Member receives the authorized service from the Community Supports Provider.

- D. Contractor must not require Member authorization for Community Supports-related data sharing as a condition of initiating delivery of Community Supports, unless such authorization is required by State or federal law.
- E. Contractor must develop and maintain policies and procedures for its network of Community Supports Providers to:
- 1) Ensure the Member agrees to receive Community Supports;
 - 2) Where required by applicable law, ensure that Members authorize information sharing with Contractor and all others involved in the Member's care as needed, to support the Member and maximize the benefits of Community Supports, in accordance with all applicable APLs, laws, and regulations;
 - 3) Provide Contractor with Member-level records of any obtained authorization for Community Supports related data sharing which are required by law, and to facilitate ongoing data sharing with Contractor; and
 - 4) Obtain Member authorization to communicate electronically with the Member, Member's family, legal guardians, authorized representatives, caregivers, and other authorized support persons, if Contractor intends to do so.

26. Data System Requirements and Data Sharing to Support Community

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Supports

- A. Contractor must use systems and processes capable of tracking Community Supports referrals, access to Community Supports, and Grievances and Appeals.

Contractor must support Community Supports Provider access to systems and processes allowing them to track and manage referrals for Community Supports and Member information.

- B. Consistent with federal, State, and if applicable, local privacy and confidentiality laws, Contractor must ensure Community Supports Providers have access to the following as part of the referral process to the Community Supports Providers:
- 1) Demographic and administrative information confirming the referred Member's eligibility and authorization for the requested service;
 - 2) Appropriate administrative, clinical, and social service information that Community Supports Providers might need to effectively provide the requested service; and
 - 3) Billing information necessary to support the Community Supports Providers' ability to submit claims or invoices to Contractor.
- C. Contractor must use defined federal and State standards, specifications, code sets, and terminologies when sharing physical, behavioral, social, and administrative data with Community Supports Providers and with DHCS.

27. Contractor's Oversight of Community Supports Providers

- A. Contractor must comply with all State and federal reporting requirements.
- B. Contractor must perform oversight of Community Support Providers, holding them accountable to all Community Supports requirements contained in this Contract, and all applicable APLs.
- C. Contractor must use all applicable APLs to develop its Subcontractor Agreements and Network Provider Agreements, as appropriate, with Community Support Providers and must incorporate all of its Community Supports Provider requirements. Contractor must submit its Subcontractor Agreements and Network Provider Agreements, as appropriate, with Community Supports Providers to DHCS for review and approval in a form and manner specified by DHCS.
- D. To streamline Community Supports implementation, Contractor must

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ensure the following:

- 1) Contractor must hold Community Supports Providers responsible for the same reporting requirements as are required of Contractor by DHCS.
 - 2) Contractor must not impose mandatory reporting requirements that are alternative or additional to those required for Encounter and supplemental reporting.
 - 3) Contractor may collaborate with other Medi-Cal Managed Care Health Plans within the same county on reporting requirements and oversight.
- E. Contractor must not utilize tools developed or promulgated by NCQA to perform oversight of Community Supports Providers, unless by mutual consent with the Community Supports Provider.
- F. Contractor must provide Community Supports training and technical assistance to Community Supports Providers, including in-person sessions, webinars, and calls, as necessary, in addition to Network Provider training requirements, as applicable, as described in Exhibit A, Attachment 7, Provision 5, Network Provider Training.

28. Delegation of Community Supports Administration to Subcontractors or Network Providers

- A. Contractor may enter into Subcontractor Agreements or Network Provider Agreements, as appropriate, with other entities to administer Community Supports in accordance with the following:
- 1) Contractor must maintain and be responsible for oversight of compliance with all Contract provisions and Covered Services, as described in Exhibit A, Attachment 6, Provision 14, Network Provider Agreements and Subcontractor Agreements;
 - 2) Contractor is responsible for developing and maintaining DHCS-approved policies and procedures to ensure Subcontractors and Network Providers meet required responsibilities and functions as described in Exhibit A, Attachment 6, Provision 14, Network Provider Agreements and Subcontractor Agreements;
 - 3) Contractor must evaluate the prospective Subcontractor's or Network Provider's ability to perform services as described in Exhibit A, Attachment 6, Provision 14, Network Provider Agreements and Subcontractor Agreements;

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- 4) Contractor must ensure the Subcontractor's or Network Provider's Community Supports Provider capacity is sufficient to serve all Populations of Focus;
 - 5) Contractor must, as applicable, report to DHCS the names of all Subcontractors by type and service(s) provided, and identify the county or counties in which Members are served; and
 - 6) Contractor must make all Subcontractor Agreements and Network Provider Agreements available to DHCS upon request. Such agreements must contain minimum required information specified by DHCS, including method and amount of compensation as described in Exhibit A, Attachment 6, Provision 14, Network Provider Agreements and Subcontractor Agreements.
- B. Contractor must ensure that Subcontractor Agreements and Network Provider Agreements, as appropriate, mirror the requirements set forth in this Contract and all applicable APLs, as applicable to the Subcontractor or Network Provider.
- C. Contractor may collaborate with its Subcontractors and Network Providers on its approach to Community Supports to minimize divergence in how the Community Supports will be implemented between Contractor and its Subcontractor(s) and Network Providers and ensure a streamlined, seamless experience for Community Supports Providers and Members.

29. Payment of Community Support Providers

- A. Contractor must pay contracted Community Supports Providers for the provision of authorized Community Supports to Members in accordance with established Subcontractor Agreements or Network Provider Agreements, as appropriate, between Contractor and each Community Supports Provider.
- B. Contractor must utilize the claims timeline and process as described in Exhibit A, Attachment 8, Provision 5, Claims Processing.
- C. Contractor must identify any circumstances under which payment for Community Supports must be expedited to facilitate timely delivery of the Community Supports to the Member, such as recuperative care for an individual who is homeless and being discharged from the hospital.

For such circumstances, Contractor must develop and maintain policies and procedures to ensure payment to the Community Supports Provider is expedited. Contractor must submit these policies and procedures to DHCS for review and approval prior to implementation.

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- D. Contractor shall ensure Community Supports Providers submit a claim for rendered Community Supports, to the greatest extent possible.
 - 1) If a Community Supports Provider is unable to submit a claim for Community Supports rendered, Contractor must ensure the Community Supports Provider documents services rendered using an invoice approved by DHCS.
 - 2) Upon receipt of such invoice, Contractor must document the Encounter for the Community Supports rendered.

30. DHCS Oversight of Community Supports

- A. In the Community Supports MOC, Contractor must include details on the Community Supports Contractor plans to offer, including which counties Community Supports will be offered and its network of Community Supports Providers, in accordance with all applicable APLs.
- B. After implementation of Community Supports, Contractor must submit the following data and reports to DHCS to support DHCS oversight of Community Supports:
 - 1) Encounter Data
 - a) Contractor must submit all Community Supports Encounter Data to DHCS using national standard specifications and code sets to be defined by DHCS. Contractor must be compliant with DHCS guidance on invoicing standards for Contractor to use with Community Supports Providers.
 - b) Contractor must submit to DHCS all Community Supports Encounter Data, including Encounter Data for Community Supports generated under Subcontractor Agreements or Network Provider Agreements.
 - c) In the event the Community Supports Provider is unable to submit Community Supports Encounter Data to Contractor using the national standard specifications and code sets to be defined by DHCS, Contractor must convert Community Supports Providers' invoice data into the national standard specifications and code sets, for submission to DHCS.
 - d) Encounter Data, when possible, must include data necessary for DHCS to stratify services by age, sex, race, ethnicity, and language spoken to inform health equity initiatives and efforts to mitigate health disparities undertaken by the DHCS.

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- 2) Supplemental reporting on a schedule and in a form to be defined by DHCS.
- C. Contractor must timely submit any related data requested by DHCS, CMS, or an independent entity conducting an evaluation of Community Supports including, but not limited to:
- 1) Data to evaluate the utilization and effectiveness of a Community Supports.
 - 2) Data necessary to monitor health outcomes and quality metrics at the local and aggregate levels through timely and accurate Encounter Data and supplemental reporting on health outcomes and equity of care. When possible, metrics must be stratified by age, sex, race, ethnicity, and language spoken.
 - 3) Data necessary to monitor Member Appeals and Grievances associated with Community Supports.
- D. In the event of underperformance by Contractor in relation to its administration of Community Supports, DHCS may impose sanctions in accordance with Exhibit E, Attachment 2, Provision 17, Sanctions.

31. Community Supports Quality and Performance Incentive Program

- A. Contractor must meet all quality management and Quality Improvement requirements described in Exhibit A, Attachment 4, Quality Improvement System and any additional quality requirements for Community Supports set forth in associated guidance from DHCS.
- B. Contractor may participate in a performance incentive program related to adoption of Community Supports, building infrastructure and Provider capacity for Community Supports, related health care quality and outcomes, and other performance milestones and measures, in accordance with APL 21-016 or other technical guidance.

32. Person-Centered Planning for Seniors and Persons with Disabilities (SPD) Beneficiaries

- A. Upon the Enrollment of a SPD beneficiary, Contractor shall provide, or ensure the provision of, Person-Centered Planning and treatment approaches that are collaborative and responsive to the SPD beneficiary's continuing health care needs.
- B. Person-Centered Planning shall include identifying each SPD beneficiary's preferences and choices regarding treatments and services, and abilities.

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- C. Contractor shall allow or ensure the participation of the SPD beneficiary, and any family, friends, and professionals of their choosing, to participate fully in any discussion or decisions regarding treatments and services.
- D. Contractor shall ensure that SPD beneficiaries receive all necessary information regarding treatment and services so that they may make an informed choice.
- E. Complex Case Management services for SPD beneficiaries must include the concepts of Person-Centered Planning.

33. Discharge Planning and Care Coordination for SPD Beneficiaries

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

- A. Documentation of pre-admission status, including living arrangements, physical and mental function, social support, Durable Medical Equipment (DME), and other services received.
- B. Documentation of pre-discharge factors, including an understanding of the medical condition by the SPD beneficiary or a representative of the SPD beneficiary as applicable, physical and mental function, financial resources, and social supports.
- C. Services needed after discharge, the type of placement preferred by the SPD beneficiary or the representative of the SPD beneficiary and hospital/institution, type of placement agreed to by the SPD beneficiary or the representative of the SPD beneficiary, the specific agency or home recommended by the hospital, the specific agency or home agreed to by the SPD beneficiary or the representative of the SPD beneficiary, and the pre-discharge counseling that is recommended.
- D. Summary of the nature and outcome of the SPD beneficiary's, or the SPD beneficiary's representative's, involvement in the discharge planning process, anticipated problems in implementing post-discharge plans, and further action contemplated by the hospital or institution.

Exhibit B
BUDGET DETAIL AND PAYMENT PROVISIONS

Budget Detail and Payment Provisions

1. Budget Contingency Clause
2. Amounts Payable
3. Contractor Risk in Providing Services
4. Capitation Rates
5. Capitation Rates Constitute Payment in Full
6. Determination of Rates
7. Redetermination of Rates-Obligation Changes
8. Reinsurance
9. Catastrophic Coverage Limitation
10. Financial Performance Guarantee
11. Recovery of Amounts Paid to Contractor
12. Medical Loss Ratio (MLR)
13. Adult Expansion Medical Loss Ratio and Risk Corridor
14. Supplemental Payments
15. Additional Payments
16. Special Contract Provisions Related to Payment
17. Medicare Coordination
18. COVIDid-19 Risk Corridor
19. State Programs Receiving Federal Financial Participation
20. Enhanced Care Management (ECM) Risk Corridor

Exhibit B
BUDGET DETAIL AND PAYMENT PROVISIONS

1. Budget Contingency Clause

- A. It is mutually agreed that if the Budget Act of the current year or any subsequent years covered under this Contract does not appropriate sufficient funds for the program, the State shall have no liability to pay any funds whatsoever to Contractor or to furnish any other considerations under this Contract, and Contractor shall not be obligated to perform any provisions of this Contract. Further, should funding for any fiscal year be reduced or deleted by the Budget Act for purposes of this program, the State shall have the option to:
- 1) Cancel this Contract with no liability occurring to the State and no further obligation by Contractor to perform, or
 - 2) Offer an Agreement amendment to Contractor to reflect the reduced amount.
- B. All payments and rate adjustments are subject to appropriations of Medi-Cal funds by the Legislature and may require Department of Finance approval. Further, all payments are subject to the availability of Federal congressional appropriation of funds.

2. Amounts Payable

Any requirement of performance by the State and Contractor for the period of the Contract will be dependent upon the availability of future appropriations by the Legislature for the purpose of the Medi-Cal program.

3. Contractor Risk In Providing Services

Contractor will assume the total risk of providing the Covered Services on the basis of the periodic Capitation Payment for each Member, except as otherwise allowed in this Contract. Any monies not expended by the Contractor after having fulfilled obligations under this Contract will be retained by the Contractor.

4. Capitation Rates

- A. DHCS shall remit to Contractor a Capitation Payment each month for each Member that appears on the approved list of Members supplied to Contractor by DHCS. The payment period for health care services shall commence on the first day of operations, as determined by DHCS.

**Exhibit B
BUDGET DETAIL AND PAYMENT PROVISIONS**

Capitation Payments shall be made in accordance with the following schedule of capitation rates. For aid codes, see DEFINITIONS, Eligible Beneficiary:

For the period 01/01/2022 – 12/31/2022	County
Groups	Rates
Adult & Family/Optional Targeted Low-Income Child (Under 19)	
Adult & Family/Optional Targeted Low-Income Child (19 & Older)	
Adult & Family/Optional Targeted Low-Income Child (Dual)	
SPD	
SPD/Dual	
SPD/Dual (Non-CCI)	
Long Term Care/Full Dual	
Long Term Care/Non-Full Dual	
Long Term Care/Full Dual (Non-CCI)	
Breast and Cervical Cancer Treatment Program (BCCTP)	
Maternity	
Adult Expansion	
Maternity Expansion	
BHT/Ages 0-6	
BHT/Ages 7-20	

- B. If DHCS creates a new aid code that is split or derived from an existing aid code covered under this Contract, and the aid code has a neutral revenue effect for the Contractor, then the split aid code will automatically be included in the same aid code rate group as the original aid code covered under this Contract. Contractor agrees to continue providing Covered Services to the Members at the Capitation Payment rate specified for the original aid code. DHCS shall confirm all aid code splits, and the rates of payment for such new aid codes, in writing to Contractor as soon as practicable after such aid code splits occur.

- C. In accordance with 42 CFR section 438.7, the actuarial basis for the computation of the Capitation Payment rates shall be set forth in DHCS' rate certification(s) for the applicable Rate Period. Subject to approval by CMS, the rate certification(s) are incorporated by reference in Exhibit E, Attachment 2, Provision 1 and made part of this Contract by this reference as if attached hereto in full.

- D. For Dual payment rates that are not identified in the schedule of Capitation Payment rates above, DHCS shall pay a capitated rate as stated in an M Letter sent to Contractor by DHCS. The M Letter shall serve as notification

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BUDGET DETAIL AND PAYMENT PROVISIONS

from DHCS to Contractor of the capitated rates for Dual payment rates not stated in this Contract, and the time period for which these rates will be applied. The M Letter shall not be considered exempt from any requirement of this Contract. The rates supplied in the M Letter will be adjusted within 30 days from the date of release.

- E. By January 1, 2015, and annually thereafter, DHCS shall provide an amendment to this Contract to add Dual payment rates that have been sent to Contractor through the M Letter.

5. Capitation Payment Rates Constitute Payment In Full

Except as otherwise specified in this Contract, the Capitation rates for each Rating Period, as calculated by DHCS and approved by CMS, are prospective rates and constitute payment in full, subject to any stop loss reinsurance provisions, on behalf of a Member for all Covered Services required by such Member and for all Administrative Costs incurred by Contractor in providing or arranging for such services under the terms of this Contract. Except as otherwise specified in the Contract, DHCS is not responsible for making payments associated with Contractor's losses.

6. Determination of Capitation Payment Rates

- A. In accordance with W&I Code Section 14301.1, DHCS shall establish Capitation Payment rates on an actuarial basis for each Rating Period, and reserves the right to redetermine and to amend such rates as necessary and appropriate. Further, all payments are subject to the availability of Federal congressional appropriation of funds.
- B. Once DHCS establishes rates on an actuarially sound basis, it shall determine whether the rates shall be increased, decreased, or remain the same. If DHCS determines that Contractor's capitation rates shall be increased or decreased, the increase or decrease shall be effectuated through an amendment or change order to this Contract. These amendments or change orders with final Capitations Payment rates shall be submitted to CMS in accordance with the provisions of Exhibit E, Attachment 2, Provision 4, Change Requirements, or upon request by the Secretary, and are subject to the following provisions:
 - 1) The amendment/change order shall be effective as of the first day of the Rating Period of each Rating Period covered by this Contract.
 - 2) In the event there is any delay in a determination or redetermination to increase or decrease Capitation Payment rates, so that an amendment or change order may not be processed in time to permit payment of new rates commencing the first day of the Rating

Exhibit B
BUDGET DETAIL AND PAYMENT PROVISIONS

Period, payment to Contractor shall continue at the rates stated in an R Letter sent to Contractor by DHCS. The R Letter shall serve as notification from DHCS to Contractor of the capitated rates, and the time period for which these rates will be applied. The R Letter shall not be considered exempt from any requirement of this Contract. Those continued payments shall constitute interim payment only. Upon CMS final approval of the amendment or change order and rate certification(s), providing for the rate change, DHCS shall make retroactive adjustments for those months for which interim payment was made.

- 3) By accepting payment of new Capitation Payment rates prior to full approval by CMS of the amendment or change order to this Contract implementing such new rates, Contractor stipulates to a confession of judgment for any and all amounts received in excess of the final approved rate. In the event that the final approved rate differs from the rates established by DHCS or agreed upon by Contractor and DHCS:
 - a) Any underpayment by the State shall be paid to Contractor within 30 calendar days after final approval of the new rates. DHCS will provide Contractor a timeframe for payment of any underpayments.
 - b) Unless otherwise required by CMS, any overpayment to Contractor shall be offset by DHCS' withholding from Contractor's future Revenues of any amount due. DHCS may, at its discretion, withhold up to 100 percent of Contractor's Revenues for each month until any overpayment is fully recovered by the State.
- 4) If mutual agreement between DHCS and Contractor cannot be attained on Capitation Payment rates for Rating Periods subsequent to September 30, 2005 resulting from a rate change pursuant to this Provision 6 or Provision 7 below, Contractor shall retain the right to terminate the Contract. Contractor's notification of intent to terminate this Contract shall be in writing and provided to DHCS at least nine months prior to the effective date of termination, subject to any earlier termination date negotiated in accordance with Exhibit E, Attachment 2, Provision 14, regarding Termination – Contractor. DHCS shall pay the Capitation Payment rates last offered for that Rating Period until the Contract is terminated.
- 5) DHCS shall make every effort to notify and consult with Contractor regarding proposed redetermination of rates pursuant to this section or Provision 7, below at the earliest possible time prior to implementation of the new rate.

Exhibit B
BUDGET DETAIL AND PAYMENT PROVISIONS

7. Redetermination of Capitation Payment Rates - Obligation Changes

Final Capitation Payment rates may be adjusted during or subsequent to the applicable Rating Period to provide for changes in obligations that result in a material projected increase or decrease of cost as determined by the certifying actuaries, in accordance with W&I Code Section 14301.1 and 42 CFR Section 438.4, or as deemed necessary by DHCS. Any adjustments shall be effectuated through an amendment or change order to the Contract subject to the following provisions:

- A. The amendment or change order shall be effective as of the first day of the month in which the change in obligations is effective, as determined by DHCS;
- B. In the event DHCS is unable to process the amendment or change order in time to permit payment of the adjusted rates as of the month in which the change in obligations is effective, payment to Contractor shall continue at the rates then in effect. Continued payment shall constitute interim payment only. Upon final approval of the amendment or change order providing for the change in obligations, DHCS shall make adjustments for those months for which interim payment was made and;
- C. DHCS and Contractor may negotiate an earlier termination date, pursuant to Exhibit E, Attachment 2, Provision 14, regarding Termination – Contractor, if a change in contractual obligations is created by a State or federal change in the Medi-Cal program, or by a lawsuit, that substantially alters the financial assumptions and conditions under which Contractor entered into this Contract, such that Contractor can demonstrate to the satisfaction of DHCS that it cannot remain financially solvent through the termination date provided by this Contract.

8. Reinsurance

Contractor may obtain reinsurance (stop loss coverage) to ensure maintenance of adequate capital by Contractor for the cost of providing Covered Services under this Contract. Pursuant to Title 22 CCR Section 53252 (a)(2)(A)&(B), reinsurance shall not limit Contractor's liability below \$5,000 per Member for any 12-month period as specified by DHCS, and Contractor may obtain reinsurance for the total cost of services provided to Members by non-contractor emergency service Providers and for 90 percent of all costs exceeding 115 percent of its income during any Contractor fiscal year.

9. Catastrophic Coverage Limitation

DHCS may limit the Contractor's liability to provide or arrange and pay for care for illness of, or injury to Members, which results from or is greatly aggravated by

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a catastrophic occurrence or disaster. Contractor will return a prorated amount of the Capitation Payment following the DHCS Director's invocation of the catastrophic coverage limitation. The amount returned will be determined by dividing the total Capitation Payment by the number of days in the month. The amount will be returned to DHCS for each day in the month after the Director has invoked the catastrophic coverage limitation clause.

10. Financial Performance Guarantee

In accordance with Title 22 CCR Section 53865, Contractor must annually provide satisfactory evidence of, and maintain a Financial Performance Guarantee in the form specified by DHCS and in an amount at least one million dollars or equal to at least three (3) months' Contract Revenues based on Contractor's average monthly Contract Revenues for last 12 months, whichever is higher, subject to approval by DHCS. At Contractor's request, and with DHCS approval, Contractor may establish a phase-in schedule to accumulate the required Financial Performance Guarantee. Unless DHCS has a financial claim or offset against Contractor, the Financial Performance Guarantee shall remain in effect through the completion of the phaseout period in accordance with Exhibit E, Provision 15 of this Contract. DHCS shall take possession of the Financial Performance Guarantee in an amount sufficient to indemnify DHCS in the event that Contractor materially breaches or defaults on one or more terms this Contract.

11. Recovery of Amounts Paid to Contractor

DHCS shall have the right to recover from Contractor amounts paid to Contractor in the following circumstances as specified:

- A. If DHCS determines that a Member has either been improperly enrolled due to ineligibility of the Member to enroll in Contractor's Medi-Cal Managed Care Health Plan, a Member's residence is outside of Contractor's Service Area, or a Member should have been disenrolled with an effective date in a prior month, DHCS may recover amounts paid to Contractor associated with the Member for the month(s) in question. In such event, to the extent permitted by law, Contractor may seek to recover any payments made to Providers for Covered Services rendered for the month(s) in question. Contractor shall inform Providers that claims for services provided to Members during the month(s) in question may be paid by the DHCS fiscal intermediary, if the Member is determined eligible for the Medi-Cal program.

Upon request by Contractor, DHCS may allow Contractor to retain amounts paid to Contractor for Members that are eligible to enroll in Contractor's Medi-Cal Managed Care Health Plan, but should have been retroactively disenrolled. In such event, Contractor shall provide or arrange and pay for all Medically Necessary Covered Services for the

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Member, until the Member is disenrolled on a non-retroactive basis pursuant to the terms set forth in Exhibit A, Attachment 16, Provision 3, Disenrollment, of this Contract.

- B. As a result of Contractor's failure to perform contractual responsibilities to comply with mandatory federal Medicaid requirements, the federal Department of Health and Human Services (U.S. DHHS) may disallow Federal Financial Participation (FFP) for payments made by DHCS to Contractor. In this event, DHCS may recover the amounts disallowed by U.S. DHHS by an offset to Contractor's Revenues. If recovery of the full amount at one time imposes a financial hardship on Contractor, Contractor may request to repay the recoverable amounts in monthly installments over a period of consecutive months not to exceed six (6) months. DHCS, at its discretion, may grant or deny such a request.
- C. If DHCS determines that an improper payment was received by Contractor for any reason not referenced in Paragraph A or B, which may include, but is not limited to, error, mistake, omission, inadvertence, delay or neglect on the part of DHCS or other entity or person, DHCS may recover the amounts determined by an offset to Contractor's Revenues. If recovery of the full amount at one time imposes a financial hardship on Contractor, DHCS, at its discretion, may grant a Contractor's request to repay the recoverable amounts in monthly installments over a period of consecutive months not to exceed six (6) months. At least 30 calendar days prior to seeking any such recovery, DHCS shall notify Contractor to explain the improper or erroneous nature of the payment and to describe the recovery process. DHCS may, at its discretion, withhold up to 100 percent of Contractor's Revenues for each month until any overpayment is fully recovered by the State.

12. Medical Loss Ratio (MLR)

The Medical Loss Ratio (MLR) as described in this Provision shall be done in accordance with 42 CFR 438.8, and shall be considered separate and distinct from the Adult Expansion Medical Loss Ratio (AE-MLR) and risk corridor as required in Exhibit B, Provision 14 of this Contract.

- A. Beginning July 1, 2017, Contractor shall calculate and report a MLR as stated in 42 CFR 438.8 and 438.604(a)(3), in a form and manner specified by DHCS.
- B. The MLR experienced by Contractor in a MLR Reporting Year is the ratio of the numerator, as stated in Paragraph C of this Provision, to the denominator, as stated in Paragraph D of this Provision. A MLR may be increased by a Credibility Adjustment, in accordance with Paragraph F of this Provision.

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- C. The numerator of Contractor's MLR for a MLR Reporting Year is the sum of Contractor's incurred claims, expenditures for activities that improve health care quality, and fraud prevention activities.
- 1) Contractor's Incurred Claims
 - a) Incurred claims must include the following:
 - i. Direct claims that Contractor paid to Providers, including under capitated contracts with Network Providers, for Covered Services or supplies under this Contract and meeting the requirements of 42 CFR 438.3(e).
 - ii. Unpaid claims liabilities for the MLR Reporting Year, including claims reported that are in the process of being adjusted or claims incurred but not reported.
 - iii. Withholds from payments made to Network Providers.
 - iv. Claims that are recoverable for anticipated coordination of benefits.
 - v. Claims payments recoveries received due to subrogation.
 - vi. Incurred but not reported claims based on past experience, and modified to reflect current conditions, such as changes in exposure or claim frequency or severity.
 - vii. Changes in other claims-related reserves.
 - viii. Reserves for contingent benefits and the medical claim portion of lawsuits.
 - b) Amounts that must be deducted from incurred claims include the following:
 - i. Overpayment recoveries received from Network Providers.
 - ii. Prescription drug rebates received and accrued.
 - c) Expenditures that must be included in incurred claims include the following:

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- i. The amount of incentive and bonus payments made, or expected to be made, to Network Providers.
- ii. The amount of claims payments recovered through fraud reduction efforts, not to exceed the amount of fraud reduction expenses. The amount of fraud reduction expenses must not include activities specified in Section C, Paragraph 3 of this Provision.
- d) Amounts that must either be included in or deducted from incurred claims include, respectively, net payments or receipts related to solvency funds mandated by DHCS.
- e) The following amounts must be excluded from incurred claims.
 - i. Non-Claims Costs, which include (1) the amounts paid to third-party vendors for secondary network savings; (2) amounts paid to third-party vendors for network development, administrative fees, claims processing, and UM; and (3) amounts paid for professional or administrative services, including amounts paid to a Provider, that do not represent compensation or reimbursement for California Medicaid State Plan services or services defined in 42 CFR 438.3(e) and provided to Members. Also included are fines and penalties assessed by regulatory authorities.
 - ii. Amounts paid to Network Providers under 42 CFR 438.6(d).
- f) Incurred claims paid by an entity that is later assumed by another entity must be reported by the assuming entity for the entire MLR Reporting Year and no incurred claims for that MLR Reporting Year may be reported by the ceding entity.
- 2) Activities that improve health care quality must be in one of the following categories:
 - a) Contractor activity that meets the requirements of 45 CFR 158.150(b) and is not excluded under 45 CFR 158.150(c).
 - b) Contractor activity related to any External Quality Review-related activity as described in 42 CFR 438.358(b) and (c).

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- c) Any Contractor expenditure that is related to health information technology and meaningful use, meets the requirements placed on issuers found in 45 CFR 158.151, and is not considered incurred claims, as defined in this Provision.
 - 3) Contractor expenditures on activities related to fraud prevention as described in 45 CFR part 158, and not including expenses for fraud reduction efforts as stated in Section C, Paragraph 1.c) ii) of this Provision.
- D. The denominator of Contractor's MLR for a MLR Reporting Year must equal the adjusted premium revenue. The adjusted premium revenue is Contractor's premium revenue minus Contractor's federal, state, and local taxes and licensing and regulatory fees, and is aggregated in accordance with this Provision.
- 1) Premium revenue includes the following for the MLR Reporting Year:
 - a) Capitation Payments, developed in accordance with 42 CFR 438.4, and excluding payments made per 42 CFR 438.6(d).
 - b) One-time payments for Member life events as specified in this Contract.
 - c) Other payments to Contractor approved under 42 CFR 438.6(b)(3).
 - d) All changes to unearned premium reserves.
 - e) Net payments or receipts related to risk sharing mechanisms developed in accordance with 42 CFR 438.5 or 438.6.
 - 2) Taxes, licensing, and regulatory fees for the MLR Reporting Year shall include:
 - a) Statutory assessments to defray the operating expenses of any state or federal department.
 - b) Examination fees in lieu of premium taxes as specified by State law.
 - c) Federal taxes and assessments allocated to Contractor, excluding federal income taxes on investment income, capital gains, and federal employment taxes.

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- d) State and local taxes and assessments including:
 - i. Any industry-wide or subset assessments, other than surcharges on specific claims, paid to the State or a locality directly.
 - ii. Guaranty fund assessments.
 - iii. Assessments of state or local industrial boards or other boards for operating expenses, or for benefits to sick employed persons in connection with disability benefit laws or similar taxes levied by the State.
 - iv. State or local income, excise, and business taxes, other than premium taxes and State employment and similar taxes and assessments.
 - v. State or local premium taxes, plus state or local taxes based on reserves, if in lieu of premium taxes.
 - e) Payments made by Contractor that are otherwise exempt from federal income taxes, for community benefit expenditures as defined in 45 CFR 158.162(c), limited to the highest of either:
 - i. Three percent (3%) of earned premium; or
 - ii. The highest premium tax rate in the State, multiplied by Contractor's earned premium in the State.
 - 3) If Contractor is later assumed by another entity that becomes the new Contractor under this Contract, the new Contractor must report the total amount of the denominator for the entire MLR Reporting Year, and no amount under this Paragraph for that year may be reported by the ceding Contractor.
- E. In the allocation of expense, Contractor shall include each expense under only one type of expense, unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense must be pro-rated between types of expenses. Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be reported on a pro rata basis. Contractor shall use the following methods to allocate expenses.
- 1) Allocation to each category must be based on a generally accepted accounting method that is expected to yield the most accurate

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results.

- 2) Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the contract incurring the expense.
- 3) Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to the other entities.

F. Contractor may add a Credibility Adjustment to a calculated MLR if the MLR Reporting Year experience is Partially Credible.

- 1) Contractor may not add a Credibility Adjustment to a calculated MLR if the MLR Reporting Year experience is Fully Credible.
- 2) If a Contractor's experience is Non-Credible, it is presumed to meet or exceed the MLR calculation standards in this Provision.
- 3) Contractor shall fulfill these requirements by using the base credibility factors that CMS publishes annually in accordance with 42 CFR section 438.8(h)(4).

G. Contractor shall aggregate data by Eligible Beneficiary groups identified in this Contract, or as otherwise directed by DHCS. This may require separate reporting and MLR calculations for specific populations.

H. MLR Reporting requirements.

- 1) Contractor shall submit a report to DHCS that includes at least the following information for each MLR Reporting Year:
 - a) Total incurred claims.
 - b) Expenditures on quality improvement activities.
 - c) Expenditures related to activities compliant with 42 CFR 438.608(a)(1)-(5), (7), (8) and (b).
 - d) Non-Claims Costs.
 - e) Premium revenue.
 - f) Taxes, licensing, and regulatory fees.
 - g) Methodology(ies) for allocation of expenditures.

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- h) Any Credibility Adjustment applied.
 - i) The calculated MLR.
 - j) Any remittance owed to DHCS, if applicable.
 - k) A comparison of the information reported with the audited financial report required under 42 CFR 438.3(m).
 - l) A description of the method used to aggregate data.
 - m) The number of Member months.
- 2) Contractor must submit this report in a timeframe and manner determined by DHCS, but no longer than 12 months after the end of the MLR Reporting Year.
 - 3) Contractor shall require any third party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to Contractor within 180 days from the end of the MLR Reporting Year, or within 30 days of being requested by Contractor, whichever comes sooner, regardless of current contracting limitations, to calculate and validate the accuracy of MLR reporting.
 - 4) Contractor shall attest to the accuracy of the MLR calculation in accordance with requirements of this Provision when submitting the MLR report.
- I. Contractor may be excluded from the requirements in this Provision in the first MLR Reporting Year of its operation. Contractor must then comply with these requirements beginning with the next MLR Reporting Year in which it contracts with DHCS, even if the first MLR Reporting Year was not a full 12 months.
 - J. In any instance where there is a retroactive change to the Capitation Payments for a MLR Reporting Year and the MLR report has already been submitted to DHCS, Contractor shall re-calculate the MLR for all MLR Reporting Years affected by the change and submit a new report meeting the reporting requirements in this Provision.

13. Adult Expansion Risk Corridor

- A. Establishment of an Adult Expansion Risk Corridor (AE Risk Corridor), based on an Adult Expansion Medical Loss Ratio (AE-MLR)

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For Adult Expansion Members, DHCS shall make additional assumptions to the benefit of both the State and Contractor for this AE Risk Corridor provision using an AE-MLR. DHCS shall perform AE-MLR calculations for the incurred periods stated below. Incurred dates align with the Net Capitation Payments and service dates of the Allowed Medical Expenses.

- 1) DHCS shall perform AE-MLR calculations for the incurred periods of January 1, 2014 to June 30, 2015, the first period, July 1, 2015 to June 30, 2016, the second period, and July 1, 2016 to June 30, 2017, the third period, and July 1, 2017 to June 30, 2018, the fourth period.
- 2) For the first and second periods, DHCS or its designee will initiate the AE-MLR calculation no sooner than 12 months after the end of each incurred period. For the third period, DHCS or its designee will initiate the AE-MLR calculation no sooner than January 1, 2019. For the fourth period, DHCS or its designee will initiate the AE-MLR calculation on April 1, 2020.
- 3) DHCS will give consideration to paid claims data at least through June 30, 2016, for services incurred during the first period, at least through June 30, 2017, for the second period, and at least through December 31, 2018, for the third period, and at least through March 31, 2020, for the fourth period.
- 4) Contractor shall provide and certify the AE Risk Corridor data and shall be subject to review or audit by DHCS or its designee.
 - a) For the fourth period, attestations will not be considered acceptable forms of documentation except when determined appropriate by DHCS in the following limited instances:
 - i. Attestations specific to the methodology used to calculate Excluded Federal Taxes and Assessments and Excluded State Taxes and Assessments; and
 - ii. Attestations specific to the classification of related and non-related party expenses.
 - b) All other attestations will be disallowed for this period. This documentation expectation does not impact the requirement for Contractor's Chief Executive Officer or Chief Financial Officer to certify that data, documentation, and information submitted for the AE Risk Corridor data is accurate, complete, and truthful for the MLR period.
- 5) The AE Risk Corridor provision applies to this Contract only and will

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end with capitation and incurred dates as of June 30, 2018.

B. AE-MLR

This Contract shall provide an AE Risk Corridor pertaining to AE-MLR for Adult Expansion Members.

- 1) Contractor shall be required to expend at least 85 percent of Net Capitation Payments received on Allowed Medical Expenses for Adult Expansion Members, for each rating region. If Contractor does not meet the minimum 85 percent AE-MLR threshold for a given rating region, then Contractor shall return to the State the difference between 85 percent of total Net Capitation Payments and actual Allowed Medical Expenses incurred for each rating region as directed by DHCS.
- 2) After completion of the AE-MLR calculation, if it is determined that Contractor's AE-MLR is less than 85 percent for a given rating region, then DHCS will notify Contractor of the Capitation Payments to be returned to the State.
- 3) Contractor shall remit to the State the full amount due within 90 calendar days of the date DHCS provides notice to Contractor of that amount.
- 4) Contractor protection is included for Allowed Medical Expenses above 95 percent of the total Net Capitation Payments received by Contractor for Adult Expansion Members, for each rating region.
 - a) If Contractor's AE-MLR exceeds 95 percent of total Net Capitation Payments under this Contract for a given rating region, then DHCS shall make additional payment to Contractor.
 - b) This additional payment from DHCS to Contractor will be the difference between the Contractor's Allowed Medical Expenses and 95 percent of Net Capitation Payments received for that rating region.
 - c) DHCS shall remit this payment to Contractor within 90 days of completion of this calculation or within 90 days of approval to claim the additional federal funds, whichever is later.
- 5) If the AE-MLR is between 85 percent and 95 percent, then there will not be an AE Risk Corridor adjustment from Contractor to DHCS or from DHCS to Contractor.

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C. Final Rates of Payment

For Adult Expansion Members, the actual payment rate for providing Covered Services under this Contract may differ from the rates initially included in this Contract, or the negotiated rate.

- 1) Actual payments may be adjusted if an adjustment is required subject to the provisions of this AE Risk Corridor methodology. Both Contractor and DHCS agree to accept the final payment levels that result from the AE Risk Corridor methodology calculation.
- 2) As a payment corridor, it is explicitly provided that this payment provision may result in payment by Contractor to DHCS or by DHCS to Contractor.
- 3) In the event of a change in capitation rate for Adult Expansion Members, for each period provided in this Provision, an AE Risk Corridor calculation in accordance with the requirements of this Provision shall be re-determined.
- 4) Subsequent to this re-determination, adjustments to payments in accordance with this Provision may result in changes in payment by Contractor to DHCS or by DHCS to Contractor.

D. AE Risk Corridor Disputes

Contractor shall have the opportunity to appeal a determination, through an appeal process defined by DHCS, that the 85 percent AE-MLR threshold has not been met and provide evidence that the required minimum has been met.

14. Supplemental Payments

- A. Contractor shall be entitled to Supplemental Payments stated within this Provision in accordance with the payment schedules set forth in this Exhibit B. Contractor must maintain on file evidence of payment for qualified services entitling them to the Supplemental Payments. Upon audit, failure to have supporting records may, upon audit, result in recoupment by DHCS of the Supplemental Payments paid to Contractor.
- 1) On a monthly basis, by no later than the twentieth (20th) calendar day following the end of each month and in a format specified by DHCS, Contractor shall submit a report for Supplemental Payments. This report shall identify the Members receiving services qualifying for Supplemental Payment and for whom Contractor is claiming payment.

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- 2) To be eligible to receive a Supplemental Payment, Contractor must properly submit all required data to DHCS within 12 months of the month of the service entitling Contractor to a Supplemental Payment. After the twelfth month following the month of service, Contractor will not receive a Supplemental Payments.

B. Maternity Supplemental Payment

- 1) Contractor shall be entitled to receive a Maternity Supplemental Payment for Members enrolled with Contractor on the date of the delivery of a child, including retroactive enrollments.
- 2) The Maternity Supplemental Payment reimburses Contractor for the projected cost of delivery as determined by DHCS.

C. Supplemental Payments for Partial Dual Eligible and Medi-Cal Only Members

- 1) Contractor shall receive a monthly Supplemental Payment for each Partial Dual Eligible Member and Medi-Cal Only Member who is identified as being in one of the Member mix categories as described in this Provision.
- 2) Contractor shall receive a Supplemental Payment for each Partial Dual Eligible Member and Medi-Cal Only Member who meets the following criteria for Institutional: Members who reside in a nursing facility for 90 days or more and are identified by Contractor in a file per Section C of this Provision. Exceptions will include Members with a LTC aid code as identified in Exhibit E, DEFINITIONS, Eligible Beneficiary.
- 3) Supplemental Payments for Partial Dual Eligible and Medi-Cal Only Members shall be made in accordance with the existing schedule of Capitation Payment rates at the end of the month. Payments for Members identified as Institutional cannot exceed the rate as stated in this Provision and will be adjusted if DHCS has sent a separate rate payment for the Member for the same month of service.

D. Supplemental Payments for BHT Services

- 1) Contractor shall receive Supplemental Payments for Members less than 21 years of age who receive qualified BHT services. Payments are based on the Member's utilization as reported by Contractor.
- 2) Contractor is required to submit a diagnosis date that can be earlier than or equal to the service date. If the diagnosis date is unknown, then Contractor is permitted to use the service date. Payment to

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Contractor is contingent upon Contractor claiming with the appropriate and most current diagnosis codes, as regularly updated.

15. Additional Payments

- A. Contractor shall be entitled to additional payments stated within this Provision, based on the payment schedules identified within Exhibit B. Contractor must maintain on file evidence of payment for qualified services entitling them to the payment. Failure to have supporting records may, upon audit, result in recoupment by DHCS of any additional payments.
- 1) On a monthly basis, by the twentieth (20th) calendar day following the end of each month and in a format specified by DHCS, Contractor shall submit a report for additional payments. This report shall identify the Members receiving services qualifying for this payment and for whom the payment amount is being claimed.
 - 2) When Contractor receives and submits data to DHCS:
 - a) Within 14 months of the month of service, Contractor will receive the full payment.
 - b) After the fourteenth month following the month of service, Contractor will not receive a payment.
- B. American Indian Health Service Program Payment
- 1) Contractor shall be entitled to receive an American Indian Health Service Program payment for Members qualified to receive services in accordance with Exhibit A, Attachment 8, Provision 7, Paragraph C of this Contract.
 - 2) The payment shall reimburse Contractor for the amount paid to American Indian Health Service Programs as required in Exhibit A, Attachment 8, Provision 7, Paragraph C of this Contract. Payments shall be based on Member utilization of qualifying services at American Indian Health Service Programs as reported by Contractor.

16. Special Contract Provisions Related to Payment

- A. Contractor must reimburse Network Providers pursuant to the terms of each applicable Directed Payment Initiative in accordance with 42 CFR section 438.6(c), in a form and manner specified by DHCS through APLs or other technical guidance. For applicable Rating Periods, DHCS shall

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make the terms of each Directed Payment Initiative available on the [DHCS website](#).

- B. Contractor must reimburse Network Providers pursuant to the terms of each applicable Pass-Through Payment established pursuant to 42 CFR section 438.6(d), in accordance with the CMS-approved rate certification, and in a form and manner specified by DHCS through APLs or other technical guidance.
- C. Contractor must comply with the terms of any Incentive Arrangements approved by CMS under 42 CFR section 438.6(b)(2), in a form and manner specified by DHCS through APLs or other technical guidance. For applicable Rating Periods, DHCS will make the terms of each approved Incentive Arrangement available on the [DHCS website](#).
- D. To participate in Member direct incentive programs approved in the Public Assistance Cost Allocation Plan (PACAP) by the U.S. Department of Health and Human Services Division of Cost Allocation Services, with CMS concurrence, Contractor must comply with the terms of those programs as set forth in the PACAP in a form and manner specified by DHCS through APLs or other technical guidance. For Rating Periods in which Member direct incentive programs are effective, commencing with the Rating Period starting January 1, 2021, DHCS shall make the terms of each approved Member direct incentive program available on the [DHCS website](#).

17. Medicare Coordination

Pursuant to 42 CFR 438.3(t), Contractor shall enter into a Coordination of Benefits Agreement with the Medicare program through CMS, and agree to participate in Medicare's automated claims crossover process for Full Benefit Dual Eligible Members.

18. COVID-19 Risk Corridor

A risk-sharing arrangement shall be in effect for complete Rating Periods covering dates of services between July 1, 2019 and December 31, 2020, for those capitation increments, services and populations, as determined by DHCS.

- A. The risk-sharing arrangement described in this Provision may result in payment by the State to Contractor or by Contractor to the State in a form and manner specified by DHCS through All Plan Letters or other technical guidance.
- B. The risk-sharing arrangement shall be symmetrical as to risk and profit and will be based on the results of a COVID-19 Risk Corridor calculation performed in a form and manner specified by DHCS through All Plan

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Letters or other technical guidance, aggregated across applicable Medical Managed Care Contracts between Contractor and the State for those capitation increments, services and populations, as determined by DHCS.

- C. Contractor shall provide and certify allowable medical expense data necessary for the COVID-19 Risk Corridor calculation in a form and manner specified by the State. The data and any related substantiating documentation is subject to review and adjustment at the State's discretion in a form and manner specified by DHCS through All Plan Letters or other technical guidance, and may be subject to audit by the State or its designee.
- D. The State or its designee will initiate the COVID-19 Risk Corridor calculation no sooner than 12 months after the end of the applicable Rating Period.

19. State Programs Receiving Federal Financial Participation

Should any part of the scope of work under this Contract relate to a State program receiving Federal Financial Participation (FFP) that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), Contractor must do no work on that part after the effective date of the loss of such program authority. DHCS must adjust capitation rates to remove costs that are specific to any State program or activity receiving FFP that is no longer authorized by law. If Contractor works on a State program or activity receiving FFP that is no longer authorized by law after the date the legal authority for the work ends, Contractor will not be paid for that work. If DHCS has paid Contractor in advance to work on a no-longer-authorized State program or activity receiving FFP and under the terms of this Contract the work was to be performed after the date the legal authority ended, the payment for that work should be returned to DHCS. However, if Contractor worked on a State program or activity receiving FFP prior to the date legal authority ended for that State program or activity receiving FFP, and DHCS included the cost of performing that work in its payments to Contractor, Contractor may keep the payment for that work even if the payment was made after the date the State program or activity receiving FFP lost legal authority.

20. Enhanced Care Management (ECM) Risk Corridor

- A. A risk-sharing arrangement shall be in effect for the Rating Period covering dates of services from January 1, 2022 through December 31, 2022, for those capitation increments, services and populations associated with ECM, as determined by DHCS.
 - 1) The risk-sharing arrangement described in this Provision may result in payment by the State to Contractor or by Contractor to the State

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in a form and manner specified by DHCS through APLs or other technical guidance.

- 2) The risk-sharing arrangement shall be symmetrical and based on the results of an ECM Risk Corridor calculation performed in a form and manner specified by DHCS through APLs or other technical guidance, aggregated across applicable Medi-Cal Managed Care Contracts between Contractor and the State for those capitation increments, services, and populations associated with ECM, as determined by DHCS.
 - 3) Contractor shall provide and certify Allowable Medical Expense data necessary for the ECM Risk Corridor calculation in a form and manner specified by DHCS. The data and any related substantiating documentation may be subject to review and adjustment at DHCS' discretion in a form and manner specified by DHCS through APLs or other technical guidance, and may be subject to audit by the State or its designee.
 - 4) DHCS or its designee will initiate the ECM Risk Corridor calculation for a given Rating Period no sooner than 12 months after the end of the applicable Rating Period.
- B. If DHCS determines that the continuation of the risk-sharing arrangement is actuarially appropriate and necessary to account for the impacts of the ECM implementation for a given Rating Period starting on or after January 1, 2023, the ECM Risk Corridor, as described in Paragraph A of this Provision, shall continue to apply in a form and manner specified by DHCS through APLs or other technical guidance for the applicable Rating Period(s).

**Exhibit E
ADDITIONAL PROVISIONS**

1. Additional Incorporated Provisions

The following Attachments 1 through 22 are incorporated herein and made a part hereof by this reference:

- Attachment 1 - Organization and Administration of the Plan
- Attachment 2 - Financial Information
- Attachment 3 - Management Information System
- Attachment 4 - Quality Improvement System
- Attachment 5 - Utilization Management
- Attachment 6 - Provider Network
- Attachment 7 - Provider Relations
- Attachment 8 - Provider Compensation Arrangements
- Attachment 9 - Access and Availability
- Attachment 10 - Scope of Services
- Attachment 11 - Case Management and External Coordination of Care
- Attachment 12 - Local Health Department Coordination
- Attachment 13 - Member Services
- Attachment 14 - Member Grievance System
- Attachment 15 - Marketing
- Attachment 16 - Enrollments and Disenrollments
- Attachment 17 - Reporting Requirements
- Attachment 18 - Implementation Plan and Deliverables
- Attachment 19 - Community Based Adult Services (CBAS)
- Attachment 20 – Behavioral Health Services
- Attachment 21 – Managed Long Term Services and Supports
- Attachment 22 – Case Management and Internal Coordination of Care

2. Priority of Provisions

In the event of a conflict between the provisions of Exhibit E and any other exhibit of this Contract, excluding Exhibit C, the provisions of Exhibit E shall prevail.

**Exhibit E, Attachment 1
DEFINITIONS**

As used in this Contract, unless otherwise expressly provided or the context otherwise requires, the following definitions of terms will govern the construction of this Contract:

Actual Non-Service Expenditures means Contractor's actual amounts incurred for non-service expenditures, including both administrative and care management costs, for Full Benefit Dual Eligible Members, or for Partial Dual Eligible Members and Medi-Cal Only Members, as applicable, and excludes costs incurred by Contractor prior to the start of this Risk Corridor. Any reinsurance costs reflected will be net reinsurance costs.

Actual Service Expenditures means Contractor's actual amount paid for providing services to Full Benefit Dual Eligible Members, or for Partial Dual Eligible Members and Medi-Cal Only Members, as applicable, priced at Contractor fee level, and shall comprise of all Provider payments for services to this population, including risk-sharing arrangements or sub-Capitation Payments.

Adjusted Non-Service Expenditures means Contractor's Actual Non-Service Expenditures, adjusted to reflect the exclusion of costs greater than 125 percent of the non-medical cost per Member per month across all participating Contractors and including any consideration given to Contractor for any significant, non-typical membership mixes that may cause this exclusion to come into effect as well as the exclusion of reinsurance costs which is the net of reinsurance premiums; and adjustments resulting from DHCS' review of Contractor's non-service expenditures to address any inappropriate or excessive non-service expenditures, including executive compensation and stop loss expenditures.

Adjusted Service Expenditures means Contractor's Actual Service Expenditures adjusted to reflect the following reductions from any recoveries of other payers outside of claims adjudication, including those pursuant to coordination of benefits, third party liability, rebates, supplemental payments, adjustments in claims paid, adjustments from Providers including adjustments to claims paid, and Member contributions to care; and adjustments resulting from DHCS' review of Contractor reimbursement methodologies and levels to address any excessive pricing.

Administrative Costs means only those costs that arise out of the operation of the plan excluding direct and overhead costs incurred in the furnishing of health care services, which would ordinarily be incurred in the provision of these services whether or not through a plan.

Adult Day Health Care (ADHC) means an organized day program of therapeutic, social and health activities and services provided to persons 55 years or older or other adults with functional impairments, either physical or mental, for the purpose of restoring or maintaining optimal capacity for self-care as set forth in Title 22, Section 78007 of the California Code of Regulations

Adult Day Health Care (ADHC) Center means a facility licensed to provide adult day health care, or a distinct portion of a licensed health facility in which such care is provided in a specialized unit, under a special permit issued by the Department

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pursuant to Title 22, Section 54105 of the California Code of Regulations.

Adult Expansion Medical Loss Ratio (AE-MLR) means the Allowed Medical Expenses for the Covered Services provided to Adult Expansion Members under this Contract divided by the amount of Medi-Cal managed care Net Capitation Payments or recorded by Contractor, by rating region. The AE-MLR will be measured by the same rating region that was used in the development of the capitation rates paid to the Contractor, under this Contract.

- A. For the first, second and third periods, the calculation excludes both the portion of Contractor's capitation revenues and associated expenses for items such as intergovernmental transfers, Hospital Quality Assurance Fees, Medi-Cal Managed Care Plan Taxes, Health Insurance Providers Fee (HIPF), Excluded Federal Taxes and Assessments, and Excluded State Taxes and Assessments.
- B. For the fourth period, the calculation excludes both the portion of Contractor's capitation revenues and associated expenses for items such as Medi-Cal Managed Care Plan Taxes, HIPF, Excluded Federal Taxes and Assessments, Excluded State Taxes and Assessments, and amounts paid under 42 CFR 438.6(d).

If a Staff Model Contractor does not account for Allowed Medical Expenses specifically by line of business and uses an allocation methodology, the AE-MLR shall be the average AE-MLR of all other Medi-Cal Managed Care Health Plans operating within the rating region in which Contractor operates. In such cases, the Staff Model Contractor's AE-MLR shall be excluded from the average AE-MLR.

Adult Expansion Member means a Member enrolled in aid codes L1, M1, and 7U as newly eligible and who meets the eligibility requirements in Title XIX of the federal Social Security Act, Section 1902(a)(10)(A)(i)(VIII), and the conditions as described in the federal Social Security Act, Section 1905(y). Expenditures for services provided to Adult Expansion Members qualify for the enhanced federal medical assistance percentage described in that section.

Affiliate means an organization or person that directly or indirectly through one or more intermediaries' controls, or is controlled by, or is under control with the Contractor and that provides services to, or receives services from, the Contractor.

Alcohol Misuse Screening and Counseling (AMSC) means services provided by a Primary Care Physician to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol.

Allied Health Personnel means specially trained, licensed, or credentialed health workers other than physicians, podiatrists and nurses.

Allowed Medical Expenses means Contractor's expenses incurred and accounted for in accordance with Generally Accepted Accounting Principles (GAAP) for Covered

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Services delivered to Members during each period, including expenses incurred for utilization management and quality assurance activities, shared risk pools, incentive payments to Providers, Payments required by Directed Payment Initiatives and excluding administrative costs as defined in Title 28 CCR Section 1300.78.

- A. For the the first, second, and third periods, designated medical expense amounts included in the capitation rates that Contractor is required to pay Providers such as intergovernmental transfers, Hospital Quality Assurance Fees, Medi-Cal Managed Care Plan Taxes, HIPF, Excluded Federal Taxes and Assessments, and Excluded State Taxes and Assessments, are excluded.
- B. For the fourth period, designated medical expense amounts included in the capitation rates that Contractor is required to pay Providers such as Medi-Cal Managed Care Plan Taxes, HIPF, Excluded Federal Taxes and Assessments, Excluded State Taxes and Assessments, and amounts paid under 42 CFR 438.6(d), are excluded.
- C. Global sub-capitation payments made by Contractor, where entire Allowed Medical Expenses are shifted to another entity, gross or net of utilization management or quality assurance, shall not exceed 95 percent, unless otherwise agreed by DHCS of the Net Capitation Payment for consideration within Allowed Medical Expenses.
- D. Payments by Contractor to related party Providers shall not exceed the rate paid by Contractor for the same services to unrelated party Providers within the same ration region. Related parties are defined by GAAP.

All Plan Letter (APL) means a document that has been dated, numbered, and issued by DHCS that provides clarification of Contractor's obligations pursuant to this Contract, and may include instructions to Contractor regarding implementation of mandated changes in State or federal statutes or regulations, or pursuant to judicial interpretation.

Alternative Format Selection (AFS) means the choice a Member or a Member's authorized representative makes to receive information and materials in an alternate format, such as Braille, large font, and electronic media, including audio or data CDs.

American Indian means a Member who meets the criteria for an "Indian" as stated in 42 CFR 438.14(a), which includes membership in a federally recognized Indian tribe, resides in an urban center and meets one or more of the criteria stated in 42 CFR 438.14(a)(ii), is considered by the Secretary of the Interior to be an Indian for any purpose, or is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

American Indian Health Service Programs means Facilities operated with funds from the Indian Health Service under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to

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the eligible American Indian population within a defined geographic area, per Title 22, Section 55000.

Ambulatory Care means the type of health services that are provided on an outpatient basis.

Appeal means a review by Contractor of an adverse benefit determination, which includes one of the following actions:

- A) A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service;
- B) A reduction, suspension, or termination of a previously authorized service;
- C) A denial, in whole or in part, of payment for a service;
- D) Failure to provide services in a timely manner; or
- E) Failure to act within the timeframes provided in 42 CFR 438.408(b).

Applied Behavioral Analysis (ABA) means the process of systematically applying interventions based upon the principles of learning theory to improve socially significant behaviors to a meaningful degree, and to demonstrate that the interventions employed are responsible for the improvement in behavior.

Autism Spectrum Disorder (ASD) means a developmental disability originating in the early development period and affecting social communication and behavior, which has been diagnosed in accordance with the Diagnostic and Statistical Manual, 5th Edition (DSM-5). ASD also includes diagnoses of Autistic Disorder, Pervasive Developmental Disorder Not Otherwise Specific (PDD-NOS), and Asperger Disorder that were made using DSM-IV criteria.

Auxiliary Aids mean supports that allow disabled Members to receive and understand information and include, but are not limited to, the use of TTY/TDD, Braille, large font of at least 18-point, and American Sign Language interpreters.

Basic Case Management means a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs. Services are provided by the Primary Care Physician (PCP) or by a PCP-supervised Physician Assistant (PA), Nurse practitioner (NP), or Certified Nurse Midwife, as the Medical Home. Coordination of carved out and linked services are considered basic case management services.

Behavioral Health Treatment (BHT) means Medically Necessary, evidence-based behavioral interventions to promote, to the maximum extent practicable, the functioning of a Member. These services are interventions designed to treat behavioral conditions

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as determined by a licensed physician, surgeon, or psychologist. BHT includes a variety of evidence-based behavioral interventions identified by nationally recognized research reviews and/or other nationally recognized scientific and clinical evidence that are designed to be delivered primarily in the home and in other community settings.

BHT Provider means a Qualified Autism Services (QAS) Provider, Professional, or Paraprofessional, as defined within the State Plan Amendment.

Beneficiary Assignment means the act of the California Department of Health Care Services (DHCS) or DHCS' enrollment contractor of notifying an Eligible Beneficiary in writing of the health plan in which the beneficiary shall be enrolled if the beneficiary fails to timely choose a health plan. If, at any time, the beneficiary notifies DHCS or DHCS' enrollment contractor of the beneficiary's health plan choice, such choice shall override the beneficiary assignment and be effective as provided in Exhibit A, Attachment 16, Provision 2.

Beneficiary Identification Card (BIC) means a permanent plastic card issued by the State to Medi-Cal recipients which is used by Contractors and Providers to verify Medi-Cal eligibility and health plan enrollment.

California Children's Services (CCS) means those services authorized by the CCS program for the diagnosis and treatment of the CCS eligible conditions of a specific Member.

California Children's Services (CCS) Eligible Conditions means a physically handicapping condition defined in Title 22 CCR Section 41800.

California Children's Services (CCS) Program means the public health program which assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of 21 years who have CCS eligible conditions.

Capitated Revenues means the amount of Medi-Cal managed care Capitation Payments/revenues paid to Contractor by DHCS for all Covered Services provided to Full Benefit Dual Eligible, or for MLTSS Covered Services and IHSS provided to Partial Dual Eligible Members and Medi-Cal Only Members, whichever is applicable, across all counties in which Contractor operates as a Medi-Cal Managed Care Health Plan.

Capitation Payment means a regularly scheduled payment made by DHCS to Contractor on behalf of each Member enrolled under this Contract and based on the actuarially sound capitation rate for the provision of Covered Services, and made regardless of whether a Member receives services during the period covered by the payment.

Care Coordination means services which are included in Basic Case Management, Complex Case Management, Enhanced Care Management, Person Centered Planning, and Discharge Planning, and are included as part of a functioning Medical Home.

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Case Manager means an individual identified as a single point-of-contact responsible for the provision of case management services and facilitation of Care Coordination for a Member.

Catastrophic Coverage Limitation means the date beyond which Contractor is not at risk, as determined by the Director, to provide or make reimbursement for illness of or injury to beneficiaries which results from or is greatly aggravated by a catastrophic occurrence or disaster, including, but not limited to, an act of war, declared or undeclared, and which occurs subsequent to enrollment.

Center of Excellence (COE) means a designation assigned to a transplant program by DHCS upon confirmation that the transplant program meets DHCS' criteria.

Claims and Eligibility Real-Time System (CERTS) means the mechanism for verifying a recipient's Medi-Cal or County Medical Services Program (CMSP) eligibility by computer.

Children with Special Health Care Needs (CSHCN) means children who have or are at increased risk for chronic physical, developmental, behavioral, or emotional condition and who also require health or related services of a type or amount beyond that required by children generally. The identification, assessment, treatment, and coordination of care for CSHCN shall comply with the requirements of 42 CFR Sections 438.208(b)(3) and (b)(4), and 42 CFR Sections 438.208(c)(2), (c)(3), and (c)(4).

Clean Claim means a claim that can be processed without obtaining additional information from the Provider of the service or from a third party.

Cold-Call Marketing means any unsolicited personal contact by the Contractor with a potential Member for the purpose of marketing (as identified within the definition of Marketing).

Community Based Adult Services (CBAS) means an outpatient, facility based service program that delivers Skilled Nursing Care, social services, therapies, personal care, family/caregiver training and support, nutrition services, transportation, and other services as defined in the Medi-Cal 2020 Waiver, to Members who meet applicable eligibility criteria.

Community Supports means services or settings that Contractor may elect to offer to eligible Members pursuant to 42 CFR section 438.3(e)(2) when the services or settings are medically appropriate and cost-effective substitutes to those required under the California Medicaid State Plan.

Community Supports Provider means entities that Contractor has determined can provide the Community Supports to eligible Members in an effective manner consistent with culturally and linguistically appropriate care, as outlined in Exhibit A, Attachment 9, Provision 13, Cultural and Linguistic Program.

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CBAS Discharge Plan of Care means a discharge plan of care based on the Member's CBAS assessment that is prepared by the CBAS Provider pursuant to 22 CCR section 78345 before the date of the Member's first reassessment, and reviewed and updated at the time of each reassessment and prior to discharge.

CBAS Emergency Remote Services (ERS) means the following services, provided in alternative service locations such as a community setting or the Member's home, and/or as appropriate, via Telehealth or live virtual video conferencing, as clinically appropriate: professional nursing care, personal care services, social services, behavioral health services, speech therapy, therapeutic activities, registered dietician-nutrition counseling, physical therapy, occupational therapy, and meals.

CBAS Provider means an ADHC Center that provides CBAS to eligible Members and has been certified as a CBAS Provider by the California Department of Aging.

Complex Case Management means the systematic coordination and assessment of care and services provided to members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services. Complex Case Management includes Basic Case Management.

Comprehensive Medical Case Management Services means services provided by a Primary Care Provider in collaboration with the Contractor to ensure the coordination of Medically Necessary health care services, the provision of preventive services in accordance with established standards and periodicity schedules and the continuity of care for an Eligible Beneficiary. It includes health risk assessment, treatment planning, coordination, referral, follow-up, and monitoring of appropriate services and resources required to meet an individual's health care needs.

Confidential Information means specific facts or documents identified as "confidential" by any law, regulations or contractual language.

Contract means this written agreement between DHCS and Contractor.

Contracting Providers means a physician, nurse, technician, teacher, researcher, hospital, home health agency, nursing home, or any other individual or institution that contracts with Contractor to provide medical services to Members.

Corrective Actions means specific identifiable activities or undertakings of the Contractor which address program deficiencies or problems.

Cost Avoid means Contractor requires a Provider to bill all liable third parties and receive payment or proof of denial of coverage from such third parties prior to Contractor paying the Provider for the services rendered.

County Department means the County Department of Social Services (DSS), or other

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county agency responsible for determining the initial and continued eligibility for the Medi-Cal program.

Covered Services means Medical Case Management and those services set forth in 22 CCR, Division 3, Subdivision 1, Chapter 3, beginning with section 51301, and 17 CCR, Chapter 4, Subchapter 13, Article 4, beginning with section 6840. Covered Services do not include:

- A. Home and Community Based Services (HCBS) Waiver Program Services as specified in Exhibit A, Attachment 11, Provisions 12 and 18 regarding Waiver Programs, and Department of Developmental Services (DDS) Administered Medicaid Home and Community Based Services Waiver. *HCBS do not include any service that is available as an Early and Periodic Screening, Diagnostic and Treatment (EPSDT) service as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under this Contract, as specified in Exhibit A, Attachment 10 regarding EPSDT services.*
- B. California Children's Services (CCS) as specified in Exhibit A, Attachment 11, Provision 7.
- C. Specialty Mental Health Services as specified in Exhibit A, Attachment 11, Provision 4.
- D. Specialty Mental Health Services provided by psychiatrists; psychologists; licensed clinical social workers; or marriage, family, and child counselors.
- E. Alcohol and substance use disorder treatment services and outpatient heroin detoxification as specified in Exhibit A, Attachment 11, Provision 5.
- F. Fabrication of optical lenses as specified in Exhibit A, Attachment 10, Provision 8.
- G. Directly observed therapy for treatment of tuberculosis as specified in Exhibit A, Attachment 11, Provision 14.
- H. Dental services as specified in W&I Code sections 14132(h), 14131.10, 14132.22, 14132.23, and 14132.88, and EPSDT dental services as described in 22 CCR section 51340.1(b). *However, Contractor is responsible for all Covered Services as specified in Exhibit A, Attachment 11, Provision 13 regarding dental services.*
- I. Chiropractic services as specified in Title 22 CCR Section 51308.
- J. Prayer or spiritual healing as specified in 22 CCR section 51312.
- K. Local Education Agency (LEA) assessment services as specified in 22 CCR Section 51360(b) provided to a Member who qualifies for LEA services based on

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22 CCR Section 51190.1.

- L. Any LEA services as specified in 22 CCR section 51360 provided pursuant to an Individualized Education Plan (IEP) as set forth in Education Code, section 56340 et seq. or an Individualized Family Service Plan (IFSP) as set forth in Government Code section 95020, or LEA services provided under an Individualized Health and Support Plan (IHSP), as described in 22 CCR section 51360.
- M. Laboratory services provided under the State serum alpha-fetoprotein-testing program administered by the Genetic Disease Branch of California Department of Public Health.
- N. Pediatric Day Health Care.
- O. Personal Care Services.
- P. State Supported Services.
- Q. Targeted case management services as specified in 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment 11, Provision 1. However, if Members under the age of 21 are not eligible for or accepted by a Regional Center or a local government health program for TCM services, Contractor shall ensure access to comparable services under the EPSDT benefit in accordance with APL 19-010.
- R. Childhood lead poisoning case management provided by county health departments.
- S. Optional benefits as set forth in W&I Code section 14131.10, as implemented by the Medi-Cal Fee-For-Service program.
- T. Prescribed covered outpatient drugs dispensed by pharmacies, in accordance with APL 22-012.
- U. Non-medical services provided by Regional Centers to individuals with developmental disabilities, including but not limited to, respite, out-of-home placement, and supportive living.
- V. End of life services as stated in Health and Safety Code section 443 et seq., and APL 16-006.

Credentialing means the recognition of professional or technical competence. The process involved may include registration, certification, licensure and professional association membership.

Credibility Adjustment means an adjustment to the MLR when Contractor is Partially

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Credible to account for a difference between the actual and target MLRs that may be due to random statistical variation.

Delivery means a live birth that generates a Vital Record for the State of California.

Department of Health and Human Services (DHHS) means the Federal agency responsible for management of the Medicaid program.

Directed Payment Initiative means a payment arrangement that directs certain expenditures made by Contractor under this Contract that is either approved by CMS as described in 42 CFR Section 438.6(c), or established pursuant to 42 CFR Sections 438.6(c)(1)(iii)(A) and 438.6(c)(2)(ii) and documented in a rate certification approved by CMS.

California Department of Health Care Services (DHCS) means the single State Department responsible for administration of the Federal Medicaid (referred to as Medical in California) Program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.

Department of Managed Health Care (DMHC) means the State agency responsible for administering the Knox-Keene Health Care Service Plan Act of 1975.

Dietitian/Nutritionist means a person who is registered or eligible for registration as a Registered Dietitian by the Commission on Dietetic Registration (Business and Professions Code, Chapter 5.65, Sections 2585 and 2586).

Directed Payment Initiative means a payment arrangement that directs certain expenditures made by Contractor under this Contract that is either approved by CMS as described in 42 CFR section 438.6(c), or established pursuant to 42 CFR Sections 438.6(c)(1)(iii)(A) and 438.6(c)(2)(ii) and documented in a rate certification approved by CMS.

Director means the Director of the California Department of Health Care Services.

Discharge Planning means planning that begins at the time of admission to a hospital or institution to ensure that necessary care, services and supports are in place in the community before individuals leave the hospital or institution in order to reduce readmission rates, improve Member and family preparation, enhance Member satisfaction, assure post-discharge follow-up, increase medication safety, and support safe transitions.

Disproportionate Share Hospital (DSH) means a health facility licensed pursuant to Health and Safety Code, Chapter 2, Division 2, to provide acute inpatient hospital services, which is eligible to receive payment adjustments from the State pursuant to Welfare and Institutions Code, Section 14105.98.

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Durable Medical Equipment (DME) means Medically Necessary medical equipment that is prescribed for the Member by Provider and is used in the Member's home, in the community or in an institution that is used as a home.

Eligible Beneficiary means any Medi-Cal beneficiary who is residing in Contractor's Service Area with one (1) of the following aid codes:

Aid Group	Mandatory Aid Codes	Non-Mandatory Aid Codes
Adult & Family/Optional Targeted Low-Income Child	01, 02, 08, 0A, 0E, 2C, 2V, 30, 32, 33, 34, 35, 38, 39, 3A, 3C, 3E, 3F, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 47, 54, 59, 5L, 5C, 5D, 5V, 72, 7A, 7J, 7S, 7W, 81, 82, 86, 8E, 8P, 8R, 8U, E6, E7, H1, H2, H3, H4, H5, K1, M3, M5, M7, M9, P5, P7, P9, R1, T1, T2, T3, T4, T5	03, 04, 06, 07, 2P, 2R, 2S, 2T, 2U, 40, 42, 43, 45, 46, 49, 4A, 4F, 4G, 4H, 4K, 4L, 4M, 4N, 4S, 4T, 4U, 4W, 5K, 5L, 76 <i>(Effective 4/1/22)</i>
Adult & Family/Optional Targeted Low-Income Child Dual	0E, 2V, 30, 32, 33, 34, 35, 38, 39, 3E, 3F, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 47, 54, 59, 5L, 5V, 72, 7A, 7J, 7W, 7X, 82, 8E, 8P, 8R, 8U, K1, M3, M7, M9, P5, P7, P9, R1	03, 04, 06, 07, 40, 42, 43, 45, 46, 49, 4A, 4F, 4G, 4H, 4K, 4L, 4M, 4N, 4S, 4T, 4U, 4W, 5K, 5L
SPD Dual	10, 14, 16, 1E, 1H, 1X, 20, 24, 26, 2E, 2H, 36, 60, 64, 66, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6V, 6X, L6	
SPD	10, 14, 16, 1E, 1H, 20, 24, 26, 2E, 2H, 36, 60, 64, 66, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6V, L6	
Adult Expansion	L1, M1, 7U	
Breast and Cervical Cancer Treatment Program (BCCTP)	0M, 0N, 0P, 0R, 0T, 0U, 0W	
Long Term Care	13, 23, 53, 63	
Long Term Care Dual	13, 23, 53, 63	

An Eligible Beneficiary may continue to be a Member following any redetermination of Medi-Cal eligibility that determines that the individual is eligible for, and the individual thereafter enrolls in, the BCCTP.

ECM Lead Care Manager means a Member's designated ECM care manager who works for the ECM Provider organization and is responsible for coordinating all aspects

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of ECM and any Community Supports as part of the Member's multi-disciplinary care team, which may include other care managers.

ECM Provider means community-based entities with experience and expertise providing intensive, in-person care management services to Members in one (1) or more of the Populations of Focus for ECM.

Emergency Medical Condition means a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- A. Placing the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- B. Serious impairment to bodily function.
- C. Serious dysfunction of any bodily organ or part.

Emergency Medical Transportation means ambulance services for an Emergency Medical Condition, and includes emergency air transportation.

Emergency Services means covered inpatient and outpatient services that are furnished by a Provider that is qualified to furnish those services and that are needed to evaluate or stabilize an emergency medical condition.

Encounter means any single medically related service rendered by (a) medical Provider(s) to a Member enrolled with Contractor during the date of service. It includes, but is not limited to, all services for which Contractor incurred any financial liability.

Enhanced Care Management (ECM) means a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-cost and/or high-need Members who meet ECM Populations of Focus eligibility criteria through a systemic coordination of services and comprehensive case management that is community-based, interdisciplinary, high-touch, and person-centered.

Encounter Data means the information that describes health care interactions between Members and Providers relating to the receipt of any item(s) or service(s) by a Member under this contract and subject to the standards of 42 CFR 438.242 and 438.818.

Enrollment means the process by which an Eligible Beneficiary becomes a Member of the Contractor's Medi-Cal Managed Care Health Plan.

Excluded Federal Taxes and Assessments means all federal taxes and assessments allocated to health insurance coverage, including but not limited to federal income taxes and the Patient Centered Outcomes Research Institute (PCORI) Fee.

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Excluded Service means a service that is covered by the Medi-Cal program but is not covered by Contractor because it is carved out of Contractor's contractual obligations for the provision of Covered Services.

Excluded State Taxes and Assessments means:

- A. Any industry-wide or subset assessments, other than surcharges on specific claims, paid to the State directly, or premium subsidies that are designed to cover the costs of providing indigent care or other access to health care throughout the State as applicable under this Contract;
- B. Guaranty fund assessments;
- C. Assessments of State industrial boards or other boards for operating expenses or for benefits to sick employed persons in connection with disability benefit laws or similar taxes levied by the State;
- D. State income, excise, and business taxes other than premium taxes;
- E. State premium taxes plus State taxes based on policy reserves, if in lieu of premium taxes; and
- F. Payments made by a Federal income tax exempt issuer for community benefit expenditures, to the extent allowed pursuant to 45 CFR 158.162(b)(1)(vii).

External Accountability Set (EAS) means a set of HEDIS® and DHCS-developed performance measures selected by DHCS for evaluation of health plan performance.

External Quality Review means an analysis and evaluation by the EQRO of aggregated information on quality, timeliness and access to the Covered Services that Contractor, Subcontractors, or Network Providers furnish to Members, as referenced for related activities in Exhibit A, Attachment 4 of this Contract.

External Quality Review Organization (EQRO) means a Peer Review Organization (PRO), PRO-like entity, or accrediting body that is an expert in the scientific review of the quality of health care provided to Medicaid beneficiaries in a state's Medicaid managed care plans, meets the competence and independence requirements set forth in 42 CFR 438.354, and is contracted with DHCS to perform External Quality Reviews and other related activities per 42 CFR 438.358.

Facility means any premise that is:

- A. Owned, leased, used or operated directly or indirectly by or for Contractor or its affiliates for purposes related to this Contract, or
- B. Maintained by a Provider to provide services on behalf of Contractor.

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Federal Financial Participation means Federal expenditures provided to match proper State expenditures made under approved State Medicaid plans.

Federally Qualified Health Center (FQHC) means an entity defined in Section 1905 of the Social Security Act (42 USC Section 1396d(l)(2)(B)).

Federally Qualified Health Maintenance Organization (FQHMO) means a prepaid health delivery plan that has fulfilled the requirements of the HMO Act, along with its amendments and regulations, and has obtained the Federal Government's qualification status under Section 1310(d) of the Public Health Service Act (42 USC Section 300e).

Fee-For-Service (FFS) means a method of payment based upon per unit or per procedure billing for services rendered to an Eligible Beneficiary.

Fee-For-Service Medi-Cal means the component of the Medi-Cal Program which Medi-Cal Providers are paid directly by the State for services not covered under this Contract.

Fee-For-Service Medi-Cal Mental Health Services (FFS/MC) means the services covered through Fee-For-Service Medi-Cal which includes mental health outpatient services and acute care inpatient services.

File and Use means a submission to DHCS that does not need review and approval prior to use or implementation, but which DHCS can require edits as determined.

Financial Performance Guarantee means cash or cash equivalents which are immediately redeemable upon demand by DHCS, in an amount determined by DHCS, which shall not be less than one full month's Capitation Payment.

Financial Statements means the Financial Statements which include a Balance Sheet, Income Statement, Statement of Cash Flows, Statement of Equity and accompanying footnotes prepared in accordance with Generally Accepted Accounting Principles.

Fiscal Year (FY) means any 12-month period for which annual accounts are kept. The State Fiscal Year is July 1 through June 30, the Federal Fiscal Year is October 1 through September 30.

Full Benefit Dual Eligible Member means a Member who is 21 years of age or older, is eligible for Medi-Cal and for benefits under Medicare Part A (42 U.S.C. Sec. 1395c et seq.) and Medicare Part B (42 U.S.C. Sec. 1395j et seq.) but who does not fall under any of the Adult Expansion aid codes.

Fully Credible means a standard, determined annually when CMS publishes base credibility factors specifying the number of Member months necessary for Contractor's experience to be to be deemed Fully Credible, where Contractor's experience is determined to be sufficient for the calculation of a MLR with a minimal chance that the difference between the actual and target MLR is not statistically significant. If

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Contractor's experience is Fully Credible, it will not receive a credibility adjustment to its MLR.

General and Administrative Expenses means expenses as defined in Title 28 CCR Section 1300.78. These expenses are not part of Allowed Medical Expenses, but are part of Net Capitation Payments.

Grievance means an oral or written expression of dissatisfaction about any matter other than an action that is an adverse benefit determination, as identified within the definition of an Appeal, and may include, but is not limited to: the quality of care or services provided, interpersonal relationships with a Provider or Contractor's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by Contractor to make an authorization decision.

Health Insurance Providers Fee (HIPF) means an annual fee starting in 2014 and paid by covered entities that provide health insurance for United States health risks during each year as described under Section 9010 of the Patient Protection and Affordable Care Act (Public Law 111-148), and as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

Health Maintenance Organization (HMO) means an organization that is not a Federally qualified HMO, but meets the State Plan's definition of an HMO including the requirements under Section 1903(m)(2)(A)(i-vii) of the Social Security Act. An organization that, through a coordinated system of health care, provides or assures the delivery of an agreed upon set of comprehensive health maintenance and treatment services for an enrolled group of persons through a predetermined periodic fixed prepayment.

Health Plan Employer Data and Information Set (HEDIS®) means the set of standardized performance measures sponsored and maintained by the National Committee for Quality Assurance.

HEDIS® Compliance Audit means an audit process that uses specific standards and guidelines for assessing the collection, storage, analysis, and reporting of HEDIS® measures. This audit process is designed to ensure accurate HEDIS® reporting.

Incentive Arrangement means any payment mechanism approved by CMS in accordance with 42 CFR section 438.6(b) under which Contractor may receive incentive payments in addition to Capitation Payments for meeting targets specified in accordance with this Contract, including but not limited to Exhibit B, Provision 17.

Individualized Plan of Care (IPC) means a written plan designed to provide the Member determined to be eligible for CBAS with appropriate treatment in accordance with the assessed needs of the Member.

In-Home Support Services (IHSS) means services provided to Members by the

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County in accordance with the requirements set forth in W & I Code Section 14186.1(c)(1), and Article 7 of the W & I Code, commencing with Section 12300 of Chapter 3, and Sections 14132.95, 14132.952, and 14132.956.

Intermediate Care Facility (ICF) means a Facility which is licensed as an ICF by DHCS or a hospital or Skilled Nursing Facility which meets the standards specified in Title 22 CCR Section 51212 and has been certified by DHCS for participation in the Medi-Cal program.

Joint Commission on the Accreditation of Health Care Organizations (JCAHO) means the organization composed of representatives of the American Hospital Association, the American Medical Association, the American College of Physicians, the American College of Surgeons, and the American Dental Association. JCAHO provides health care accreditation and related services that support performance improvement in health care organizations.

Knox-Keene Health Care Service Plan Act of 1975 means the law that regulates HMOs and is administrated by the DMHC, commencing with, Health and Safety Code Section 1340.

Laboratory Testing Site means any laboratory and any Provider site, such as a PCP or Specialist office or clinic, that performs tests or examinations on human biological specimens derived from the human body.

Long-Term Care (LTC) means care provided in a skilled nursing facility and sub-acute care services that lasts longer than 60 days.

Managed Long Term Services and Support (MLTSS) means services and supports provided by Contractor to Members who have functional limitations and/or chronic illnesses and which have the primary purpose of supporting the ability of the Member to live or work in the setting of their choice, which may include the Member's home, a worksite, a Provider-owned or controlled residential setting, a nursing facility, or other institutional setting. In this Contract, MLTSS includes CBAS, LTC, and SNFs, to the extent Contractor is at-risk for covering SNF services.

Marketing means any activity conducted by or on behalf of the Contractor where information regarding the services offered by the Contractor is disseminated in order to persuade or influence Eligible Beneficiaries to enroll. Marketing also includes any similar activity to secure the endorsement of any individual or organization on behalf of the Contractor.

Marketing Materials means materials produced in any medium, by or on behalf of the Contractor that can reasonably be interpreted as intended to market to Potential Enrollees.

Marketing Representative means a person who is engaged in Marketing activities on behalf of the Contractor.

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Medi-Cal Eligibility Data System (MEDS) means the automated eligibility information processing system operated by the State which provides on-line access for recipient information, update of recipient eligibility data and on-line printing of immediate need beneficiary identification cards.

Medi-Cal Managed Care Health Plan means a managed care health plan that contracts with the Department of Health Care Services for provision or arrangement of Medi-Cal benefits and services.

Medi-Cal Managed Care Plan Taxes mean the extension of the State sales tax to sellers of Medi-Cal Managed Care plans for the privilege of selling Medi-Cal related health care services at retail in California as described under Revenue and Taxation Code Sections 6174 through 6189, and any successor State managed care organization provider tax applicable to Contractor.

Medi-Cal Only Member means a Member who is eligible for only Medi-Cal and receives CBAS or LTC services from Contractor.

Medi-Cal Provider Manual means the multi-part document published and maintained by DHCS at http://files.medi-cal.ca.gov/pubsdoco/Manuals_menu.asp. The Manual includes program overviews, eligibility requirements, billing and claiming requirements, and instructions relating to specific programs and Provider types.

Medical Home means a place where a Member's medical information is maintained and care is accessible, continuous, comprehensive and culturally competent. A Medical Home shall include at a minimum: a Primary Care Physician (PCP) who provides continuous and comprehensive care; a physician-directed medical practice where the PCP leads a team of individuals who collectively take responsibility for the ongoing care of a Member; whole person orientation where the PCP is responsible for providing all of the Member's health care needs or appropriately coordinating care; optimization and accountability for quality and safety by the use of evidence-based medicine, decision support tools, and continuous quality improvement; ready access to assure timely preventive, acute and chronic illness treatment in the appropriate setting; and payment which is structured based on the value of the patient-centered medical home and to support care management, coordination of care, enhanced communication, access and quality measurement services. This definition can change to include all standards as set forth in W&I Code 14182(c)(13)(B).

Medical Loss Ratio (MLR) Reporting Year means a period of 12 months rating period established by DHCS.

Medical Records means written documentary evidence of treatments rendered to plan Members.

Medically Necessary or **Medical Necessity** means reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or

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alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.

For Members under 21 years of age, a treatment or service is Medically Necessary if it is necessary to correct or ameliorate defects and physical and mental illnesses or conditions under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard set forth in 42 USC Section 1396d(r)(5), as required by W&I Code Sections 14059.5(b) and 14132(v), and as described in APL 19-010. Contractor shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child.

Member means any Eligible Beneficiary who has enrolled in the Contractor's plan. For the purposes of this Contract, "Enrollee" shall have the same meaning as "Member."

Member Evaluation Tool (MET) means the information collected from a Health Information Form (HIF), a high-level initial assessment completed by Members at the time of enrollment through which they may self-identify disabilities, acute and chronic health conditions, and transitional service needs. For newly enrolled SPD beneficiaries Contractor must use the MET as part of the health risk assessment process.

Minimum Performance Level refers to a minimum requirement of performance of Contractor on each of the External Accountability Set measures.

Minor Consent Services means those Covered Services of a sensitive nature which minors do not need parental consent to access, related to:

- A. Sexual assault, including rape.
- B. Drug or alcohol abuse for children 12 years of age or older.
- C. Pregnancy.
- D. Family planning.
- E. Sexually transmitted diseases (STDs), designated by the Director, in children 12 years of age or older.
- F. Outpatient mental health care for children 12 years of age or older who are mature enough to participate intelligently and where either (1) there is a danger of serious physical or mental harm to the minor or others or (2) the children are the alleged victims of incest or child abuse.

Model of Care (MOC) means Contractor's framework for providing ECM and Community Supports, including its Policies and Procedures for partnering with ECM and Community Supports Providers.

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Multipurpose Senior Service Program (MSSP) means the Waiver program that provides social and health care management to a Member who is 65 years or older and meets a nursing facility level of care as an alternative to nursing facility placement in order to allow the Member to remain in their home, pursuant to the Medi-Cal 2020 Waiver. Effective January 1, 2022, MSSP will no longer be part of the MLTSS benefit provided by Contractor and will no longer be covered in the Contract.

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

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

Net Capitation Payments means for the first, second and third periods Contractor's capitation revenues less designated amounts included in capitation rates that Contractor is required to pay to Providers such as intergovernmental transfers, Hospital Quality Assurance Fees, Medi-Cal Managed Care Plan Taxes, HIPF, Excluded Federal Taxes and Assessments, and Excluded State Taxes and Assessments. For the fourth period, Contractor's capitation revenues, including amounts related to Directed Payment Initiatives, less designated amounts included in capitation rates that Contractor is required to pay to Providers such as Medi-Cal Managed Care Plan Taxes, HIPF, Excluded Federal Taxes and Assessments, Excluded State Taxes and Assessments, and amounts paid under 42 CFR 438.6(d). For all periods. Net Capitation Payments shall exclude retroactive adjustments relating to the prior service period(s) and shall include amounts accrued/recognized for the service period in accordance with GAAP.

Network means PCPs, Specialists, hospitals, ancillary Providers, Facilities, and any other Providers with whom Contractor enters into a Network Provider Agreement.

Network Provider means any Provider or entity that has a Network Provider Agreement with Contractor or Contractor's Subcontractor, and receives Medi-Cal funding directly or indirectly to order, refer, or render Covered Services under this Contract. A Network Provider is not a Subcontractor by virtue of the Network Provider Agreement.

Network Provider Agreement means a written agreement between a Network Provider and Contractor or Subcontractor.

Newborn Child means a child born to a Member during her membership or the month prior to her membership.

Non-Claims Costs means those expenses for administrative services that are not incurred claims, expenditures on activities that improve health care quality, licensing and regulatory fees, or federal and state taxes.

Non-Credible means a standard, determined annually when CMS publishes base

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credibility factors specifying the number of Member months necessary for Contractor's experience to be deemed Non-Credible, where Contractor's experience is determined to be insufficient for the calculation of a MLR.

Non-Emergency Medical Transportation (NEMT) means ambulance, litter van or wheelchair van medical transportation services. NEMT is used when the Member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for the purpose of obtaining needed medical care, and per Title 22 CCR Sections 51323, 51231.1, and 51231.2, is rendered by licensed Providers.

Non-Medical Transportation (NMT) means transportation of Members to obtain covered Medi-Cal services by passenger car, taxicabs, or other forms of public or private conveyances, and mileage reimbursement when conveyance is in a private vehicle arranged by the Member and not through a transportation broker, bus passes, taxi vouchers, or train tickets. NMT does not include the transportation of sick, injured, invalid, convalescent, infirm, or otherwise incapacitated Members by ambulances, litter vans, or wheelchair vans licensed, operated and equipped in accordance with State and local statutes, ordinances, or regulations.

Non-Physician Medical Practitioners (Mid-Level Practitioner) means a nurse practitioner, certified nurse midwife, or physician assistant authorized to provide Primary Care under Physician supervision.

Non-Quantitative Treatment Limitation (NQTL) means a limit on the scope or duration of benefits.

Non-Specialty Mental Health Services (NSMHS) means all of the following services that Contractor must provide when they are Medically Necessary, and is provided by PCPs or by licensed mental health Network Providers within their scope of practice:

- A. Mental health evaluation and treatment, including individual, group, and family psychotherapy;
- B. Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition;
- C. Outpatient services for the purposes of monitoring drug therapy;
- D. Psychiatric consultation, excluding separately billable psychiatric drugs claimed by outpatient pharmacy providers via Medi-Cal Rx.; and
- E. Outpatient laboratory, drugs, supplies, and supplements, excluding separately billable drugs claimed by outpatient pharmacy providers via Medi-Cal Rx.

Notice of Action (NOA) means the notification of an adverse benefit determination that is sent by Contractor to a Member in accordance with the notice and timing

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requirements set forth in 42 CFR 438.404.

Not Reported means: 1) Contractor calculated the measure but the result was materially biased; 2) Contractor did not calculate the measure even though a population existed for which the measure could have been calculated; and/or, 3) Contractor calculated the measure but chose not to report the rate.

Nurse means a person licensed by the California Board of Nursing as, at least, a Registered Nurse (RN).

Other Health Coverage (OHC) means health coverage from another entity that is responsible for payment of the reasonable value of all or part of the health care services provided to a Member. OHC may result from a health insurance policy or other contractual agreement or legal obligation to pay for health care services provided to a Member, excluding tort liability. OHC may originate under State (other than the Medicaid program), Federal, or local medical care program, or under other contractual or legal entitlements.

Other Health Coverage (OHC) means health coverage from another entity that is responsible for payment of the reasonable value of all or part of the health care services provided to a Member. OHC may result from a health insurance policy or other contractual agreement or legal obligation to pay for health care services provided to a Member, excluding tort liability. OHC may originate under State (other than the Medicaid program), Federal, or local medical care program, or under other contractual or legal entitlements.

Out-of-Network Provider means a Provider that does not participate in Contractor's Network.

Outpatient Care means treatment provided to a Member who is not confined in a health care facility.

Overpayment means any payment made by Contractor to a Network Provider to which the Network Provider is not entitled to under Title XIX of the Act or any payment to Contractor by DHCS to which Contractor is not entitled to under Title XIX of the Act.

Partially Credible means a standard, determined annually when CMS publishes base credibility factors specifying the number of Member months necessary for Contractor's experience to be determined Partially Credible, where Contractor's experience is sufficient for the calculation of a MLR, but with a non-negligible chance that the difference between the actual and target MLRs is statistically significant. If Contractor's experience is Partially Credible, it will receive a credibility adjustment to its MLR.

Partial Dual Eligible Member means a Member who is 21 years of age or older and is eligible for Medi-Cal, and who is also eligible for benefits under either Medicare Part A (42 U.S.C. Sec. 1395c et seq.) or Medicare Part B (42 U.S.C. Sec. 1395j et seq.).

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Pass-Through Payment means the “Pass-through payment,” as defined in 42 CFR 438.6(a) that has been documented in a rate certification approved by CMS.

Pediatric Subacute Care means health care services needed by a person under 21 years of age who uses a medical technology that compensates for the loss of vital bodily function. Medical Necessity criteria are described in the Physician's Manual of Criteria for Medi-Cal Authorization.

Performance Improvement Projects (PIPs) means studies selected by Medi-Cal Managed Care Health Plans, either independently or in collaboration with DHCS and other participating Medi-Cal Managed Care Health Plans, to be used for performance improvement purposes. The studies include four (4) phases and may occur within a 24-month time frame.

Person-Centered Planning means an ongoing process designed to develop an individualized care plan specific to each person's abilities and preferences. Person-centered planning is an integral part of Basic and Complex Case Management and Discharge Planning.

Physician means a person duly licensed as a physician by the Medical Board of California.

Physician Incentive Plan means any compensation arrangement between Contractor and a physician or a physician group that may not directly or indirectly have the effect of reducing or limiting services provided to Members under this Contract.

Policy Letter means a document that has been dated, numbered, and issued by the Medi-Cal Managed Care Division, provides clarification of Contractor's obligations pursuant to this Contract, and may include instructions to the Contractor regarding implementation of mandated changes in State or Federal statutes or regulations, or pursuant to judicial interpretation.

Population of Focus means a subset of Medi-Cal Managed Care Health Plan Members that meet eligibility criteria, as defined by DHCS, by which they are eligible to receive the ECM benefit.

Post-Payment Recovery means Contractor pays the Provider for the services rendered and then uses all reasonable efforts to recover the cost of the services from all liable third parties.

Potential Enrollee means a Medi-Cal recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific plan.

Prescription Drug means a drug and/or medication that can only be accessed by prescription.

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Preventive Care means health care designed to prevent disease and/or its consequences.

Primary Care means a basic level of health care usually rendered in ambulatory settings by general practitioners, family practitioners, internists, obstetricians, pediatricians, and mid-level practitioners. This type of care emphasizes caring for the Member's general health needs as opposed to Specialists focusing on specific needs.

Primary Care Physician (PCP) means a physician responsible for supervising, coordinating, and providing initial and primary care to patients and serves as the Medical Home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For SPD beneficiaries, a PCP may also be a Specialist or clinic in accordance with W & I Code 14182 (b)(11).

Primary Care Provider means a person responsible for supervising, coordinating, and providing initial and primary care to patients; for initiating referrals; and for maintaining the continuity of patient care. A Primary Care Provider may be a Primary Care Physician (PCP) or Non-Physician Medical Practitioner.

Prior Authorization means a formal process requiring a Provider to obtain advance approval of Covered Services Medically Necessary and to what amount, duration, and scope, except in the case of an emergency.

Program Data means data that includes, but is not limited to: Grievance data, Appeals data, medical exemption request denial reports and other continuity of care data, Out-of-Network request data, and PCP assignment data as of the last calendar day of the reporting month.

Provider means any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.

Provider Grievance means an oral or written expression of dissatisfaction, including any complaint, dispute, request for reconsideration or appeal made by a Provider. DHCS considers Provider complaints and appeals the same as a Provider Grievance.

Provider-Preventable Condition (PPC) means a condition occurring in an inpatient hospital setting, or a condition occurring in any health care setting, that meets the criteria as stated in 42 CFR 447.26(b).

Qualified Autism Services (QAS) Provider means a licensed practitioner or Board Certified Behavior Analyst (BCBA).

QAS Professional means an Associate Behavioral Analyst, Behavior Analyst, Behavior Management Assistant, or Behavior Management Consultant, as defined in the State Plan Amendment, who provides Medically Necessary BHT services to Members.

QAS Paraprofessional means an individual who is employed and supervised by a

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QAS Provider to provide Medically Necessary BHT services to Members.

Quality Improvement (QI) means the result of an effective Quality Improvement System.

Quality Improvement System (QIS) means the systematic activities to monitor and evaluate the medical care delivered to Members according to the standards set forth in regulations and contract language. Contractor must have processes in place, which measure the effectiveness of care, identify problems, and implement improvement on a continuing basis.

Quality of Care means the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

Quality Indicators means measurable variables relating to a specific clinic or health services delivery area which are reviewed over a period of time to screen delivered health care and to monitor the process or outcome of care delivered in that clinical area.

Quantitative Treatment Limitation (QTL) means a limit on the scope or duration of a benefit that is expressed numerically.

Rating Period means a period of time selected by DHCS for which actuarially sound capitation rates are developed and documented in the rate certification submitted to CMS pursuant to 42 section CFR 438.7(a).

Revenue means the amount of Capitation Payments, Supplemental Payments, additional payments, and other revenue paid to Contractor by DHCS under this Contract.

Rural Health Clinic (RHC) means an entity defined in Title 22 CCR Section 51115.5.

Safety-Net Provider means any Provider of comprehensive primary care or acute hospital inpatient services that provides these services to a significant total number of Medi-Cal and charity and/or medically indigent patients in relation to the total number of patients served by the Provider. Examples of Safety-Net Providers include Federally Qualified Health Centers; governmentally operated health systems; community health centers; Rural and American Indian Health Service Programs; disproportionate share hospitals; and public, university, rural, and children's hospitals.

Seniors and Persons with Disabilities (SPD) means Medi-Cal beneficiaries who fall under specific SPD aid codes as defined by the department (See Eligible Beneficiary).

Service Area means the county or counties that the Contractor is approved to operate in under the terms of this Contract. A Service Area may have designated zip Codes (under the U.S. Postal Service) within a county that are approved by DHCS to operate under the terms of this Contract.

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Service Authorization Request means a Member's request for the provision of a Covered Service.

Service Location means any location at which a Member obtains any health care service provided by the Contractor under the terms of this Contract.

Significant Change means changes in Covered Services, benefits, the geographic Service Area, composition of payments to its Network, or enrollment of a new population, as stated in APL 21-006.

Skilled Nursing Care means Covered Services provided by licensed nurses, technicians, and/or therapists during a stay in a Skilled Nursing Facility or in a Member's home.

Skilled Nursing Facility (SNF) means, as defined in Title 22 CCR Section 51121(a), any institution, place, building, or agency which is licensed as a SNF by DHCS or is a distinct part or unit of a hospital, meets the standard specified in Section 51215 of these regulations (except that the distinct part of a hospital does not need to be licensed as a SNF) and has been certified by DHCS for participation as a SNF in the Medi-Cal program. Section 51121(b) further defines the term "Skilled Nursing Facility" as including terms "skilled nursing home", "convalescent hospital", "nursing home," or "nursing facility."

Social Drivers of Health means the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health functioning, and quality-of-life outcomes and risk.

Specialist means a Physician who has completed advanced education and clinical training in a specific area of medicine or surgery.

Specialty Care Center means a center that is accredited or designated by the State or federal government, or by a voluntary national health organization, as having special expertise in treating the life-threatening disease or condition or degenerative and disabling disease or condition for which it is accredited or designated.

Specialty Mental Health Provider means a person or entity who is licensed, certified or otherwise recognized or authorized under State law governing the healing arts and who meets the standards for participation in the Medi-Cal program to provide Specialty Mental Health Services.

Specialty Mental Health Service means:

- A. Rehabilitative services, which includes mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services, and psychiatric health facility services;

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- B. Psychiatric inpatient hospital services;
- C. Targeted Case Management;
- D. Psychiatrist services;
- E. Psychologist services; and
- F. EPSDT Specialty Mental Health Services.

Staff Model Contractor means a Health Maintenance Organization (HMO) that directly employs salaried Providers, and its Providers who only practice out of the HMO's buildings, and who may only provide services to its own Members.

Staff Model Providers means a Staff Model Contractor that has an agreement with Contractor to provide Covered Services to Contractor's Members.

Standing Referral means a referral by a Primary Care Physician to a Specialist for more than one visit to the Specialist, as indicated in the treatment plan, if any, without the primary care physician having to provide a specific referral for each visit.

State means the State of California

State Supported Services means those services that are provided under a different contract between the Contractor and the Department.

Subacute Care means, as defined in Title 22 CCR Section 51124.5, a level of care needed by a patient who does not require hospital acute care but who requires more intensive licensed Skilled Nursing Care than is provided to the majority of patients in a SNF.

Subcontractor means an individual or entity that has a Subcontractor Agreement with Contractor or Contractor's Subcontractor that relates directly or indirectly to the performance of Contractor's obligations under this Contract with. A Network Provider is not a Subcontractor by virtue of a Network Provider Agreement.

Subcontractor Agreement means a written agreement between Contractor or Contractor's Subcontractor and a Subcontractor.

Supplemental Payment means a payment, in addition to the Capitation Payment, made by DHCS to Contractor in accordance with Exhibit B, Provision 14 of this Contract, related to a specific instance, as defined by DHCS, of Contractor's provision of qualified Covered Services to a Member enrolled under this Contract.

Supplemental Security Income (SSI) means the program authorized by Title XVI of the Social Security Act for aged, blind, and disabled persons.

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Targeted Case Management (TCM) means services which assist Medi-Cal Members within specified target groups to gain access to needed medical, social, educational and other services. In prescribed circumstances, TCM is available as a Medi-Cal benefit as a discrete service, as well as through State or local government entities and their contractors.

Telehealth means a method of delivering health care services by using information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a Member's health care while the Member is at a separate location from the health care Provider.

Third Party Tort Liability (TPTL) means the responsibility of an individual or entity other than Contractor or the Member for the payment of claims for injuries, or trauma sustained by a Member. This responsibility may be contractual, a legal obligation, or as a result of, or the fault or negligence of, third parties (e.g., auto accidents or other personal injury casualty claims or Workers' Compensation appeals).

Traditional Provider means any physician who has delivered services to Medi-Cal beneficiaries within the last six months either through FFS Medi-Cal or a Medi-Cal Managed Care plan. The term includes physician and hospital Providers only, either profit or non-profit entities, publicly or non-publicly owned and operated.

Urgent Care means services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury (i.e., sore throats, fever, minor lacerations, and some broken bones).

Utilization Review means the process of evaluating the necessity, appropriateness, and efficiency of the use of medical services, procedures and Facilities.

Vaccines for Children (VFC) Program means the Federally funded program that provides free vaccines for eligible children (including all Medi-Cal eligible children age 18 or younger) and distributes immunization updates and related information to participating Providers. Providers contracting with the Contractor are eligible to participate in this program.

Working Day(s) mean State calendar (State Appointment Calendar, Standard 101) working day(s).

**Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS**

1. Governing Law

In addition to Exhibit C, Provision 14. Governing Law, the following provisions apply:

A. If it is necessary to interpret this Contract, all applicable laws may be used as aids in interpreting the Contract. However, the parties agree that any such applicable laws shall not be interpreted to create contractual obligations upon DHCS or Contractor, unless such applicable laws are expressly incorporated into this Contract in some section other than this provision, Governing Law. Except for Provision 16. Sanctions, and Provision 17. Liquidated Damages below, the parties agree that any remedies for DHCS' or Contractor's non-compliance with laws not expressly incorporated into this Contract, or any covenants implied to be part of this Contract, shall not include money damages, but may include equitable remedies such as injunctive relief or specific performance. This Contract is the product of mutual negotiation, and if any ambiguities should arise in the interpretation of this Contract, both parties shall be deemed authors of this Contract.

B. Any provision of this Contract which is in conflict with current or future applicable Federal or State laws or regulations is hereby amended to conform to the provisions of those laws and regulations. Such amendment of the Contract shall be effective on the effective date of the statutes or regulations necessitating it, and shall be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

Such amendment shall constitute grounds for termination of this Contract in accordance with the procedures and provisions of Provision 14, Paragraph C. Termination – Contractor below. The parties shall be bound by the terms of the amendment until the effective date of the termination.

C. Unless otherwise specified in this Contract, Contractor shall comply with all applicable provisions of the California Medicaid State Plan, and any current and applicable amendments thereto. The State Plan and all State Plan Amendments can be viewed at:

www.dhcs.ca.gov/formsandpubs/laws/Pages/CaliforniStatePlan.aspx

D. Contractor shall comply with all existing final PLs and APLs issued by DHCS. Final PLs and APLs can be viewed at:

www.dhcs.ca.gov/formsandpubs/Pages/MgdCarePlanPolicyLtrs.aspx

1) All PLs and APLs issued by DHCS subsequent to the effective date and during the term of this Contract shall provide clarification of

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PROGRAM TERMS AND CONDITIONS**

Contractor's obligations pursuant to this Contract, and may include instructions to Contractor regarding implementation of mandated obligations pursuant to changes in State or federal statutes or regulations, or pursuant to judicial interpretation.

2) In the event there is an inconsistency between this Contract as stated in Paragraph B above and a DHCS APL or PL, the Contract shall prevail.

E. Unless otherwise specified in this Contract, Contractor shall comply with all current and applicable provisions of the Medi-Cal Provider Manual, unless the Medi-Cal Provider Manual conflicts with this Contract, APLs, and/or any applicable federal or State laws, regulations, in which case the specific terms of this Contract, the APL, or the applicable law will apply.

2. Entire Agreement

This written Contract and any amendments shall constitute the entire agreement between the parties. No oral representations shall be binding on either party unless such representations are reduced to writing and made an amendment to the Contract.

3. Amendment Process

In addition to Exhibit C, Provision 2. Amendment, Contractor also agrees to the following:

Should either party, during the life of this Contract, desire a change in this Contract, that change shall be proposed in writing to the other party. The other party shall acknowledge receipt of the proposal within ten (10) calendar days of receipt of the proposal. The party proposing any such change shall have the right to withdraw the proposal any time prior to acceptance or rejection by the other party. Any proposal shall set forth an explanation of the reason and basis for the proposed change and the text of the desired amendment to this Contract which would provide for the change. If the proposal is accepted, this Contract shall be amended to provide for the change mutually agreed to by the parties on the condition that the amendment is approved by DHHS, and the State Department of Finance, if necessary.

4. Change Requirements

A. General Provisions

The parties recognize that during the life of this Contract, the Medi-Cal Managed Care program will be a dynamic program requiring numerous changes to its operations and that the scope and complexity of changes will vary widely over the life of the Contract. The parties agree that the

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development of a system which has the capability to implement such changes in an orderly and timely manner is of considerable importance.

B. Contractor's Obligation to Implement

The Contractor will make changes mandated by DHCS. In the case of mandated changes in regulations, statutes, Federal guidelines, or judicial interpretation, DHCS may direct the Contractor to immediately begin implementation of any change by issuing a change order. If DHCS issues a change order, the Contractor will be obligated to implement the required changes while discussions relevant to any capitation rate adjustment, if applicable, are taking place.

DHCS may, at any time, within the general scope of the Contract, by written notice, issue change orders to the Contract.

C. Moral or Religious Objections to Providing a Service

If the Contractor has a moral or religious objection to providing a service or referral for a service for which the Contractor is not responsible, during the term of this agreement, the Contractor shall notify the DHCS in writing providing sufficient detail to establish the moral or religious grounds for the objection.

5. Delegation of Authority

DHCS intends to implement this Contract through a single administrator, called the "Contracting Officer". The Director of DHCS will appoint the Contracting Officer. The Contracting Officer, on behalf of DHCS, will make all determinations and take all actions as are appropriate under this Contract, subject to the limitations of applicable Federal and State laws and regulations. The Contracting Officer may delegate his/her authority to act to an authorized representative through written notice to the Contractor

Contractor will designate a single administrator; hereafter called the "Contractor's Representative". The Contractor's Representative, on behalf of the Contractor, will make all determinations and take all actions as are appropriate to implement this Contract, subject to the limitations of the Contract, Federal and State laws and regulations. The Contractor's Representative may delegate his/her authority to act to an authorized representative through written notice to the Contracting Officer. The Contractor's Representative will be empowered to legally bind the Contractor to all agreements reached with DHCS.

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Contractor shall designate Contractor's Representative in writing and shall notify the Contracting Officer in accordance with Exhibit E, Attachment 2, Provision 10, Notices.

6. Authority of the State

Sole authority to establish, define, or determine the reasonableness, the necessity and level and scope of covered benefits under the Medi-Cal Managed Care program administered in this Contract or coverage for such benefits, or the eligibility of the beneficiaries or Providers to participate in the Medi-Cal Managed Care Program reside with DHCS.

Sole authority to establish or interpret policy and its application related to the above areas will reside with DHCS.

The Contractor may not make any limitations, exclusions, or changes in benefits or benefit coverage; any changes in definition or interpretation of benefits; or any changes in the administration of the Contract related to the scope of benefits, allowable coverage for those benefits, or eligibility of beneficiaries or Providers to participate in the program, without the express, written direction or approval of the Contracting Officer.

7. Fulfillment of Obligations

No covenant, condition, duty, obligation, or undertaking continued or made a part of this Contract will be waived except by written agreement of the parties hereto, and forbearance or indulgence in any other form or manner by either party in any regard whatsoever will not constitute a waiver of the covenant, condition, duty, obligation, or undertaking to be kept, performed or discharged by the party to which the same may apply; and, until performance or satisfaction of all covenants, conditions, duties, obligations, and undertakings is complete, the other party will have the right to invoke any remedy available under this Contract, or under law, notwithstanding such forbearance or indulgence.

8. Obtaining DHCS Approval

Contractor shall obtain written approval from DHCS, as provided in Exhibit E, Attachment 3, Provision 5. DHCS Approval Process, prior to commencement of operation under this Contract.

DHCS reserves the right to review and approve any changes to Contractor's protocols, policies, and procedures as specified in this Contract.

9. Certifications

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- A. Contractor shall certify all data, information, and documentation submitted to DHCS pursuant to 42 CFR 438.604, APL 17-005, and as listed below, in a form and manner specified by DHCS:
- 1) Encounter Data;
 - 2) Data used by the State to certify actuarial soundness of capitation rates;
 - 3) Medical Loss Ratio (MLR) data as set forth in 42 CFR 438.604(a)(3);
 - 4) Provisions against risk of insolvency as set forth in 42 CFR 438.604(a)(4);
 - 5) Documentation described in 42 CFR 438.207(b) used to certify compliance with this Contract's requirements for accessibility and availability of services, including Network adequacy;
 - 6) Contractor's information on ownership and control, including its Subcontractors and Network Providers;
 - 7) The annual report of Overpayment recoveries as required in 42 CFR 438.608(d)(3);
 - 8) Documentation confirming compliance with this Contract's interoperability requirements and APL 22-026 that is certified by Contractor's CEO or CFO and in accordance with submission requirements in APL 17-005; and
 - 9) Any other data, documentation, or information requested by DHCS relating to the performance of Contractor's obligations under this Contract.
- B. Certification must comply with the requirements of 42 CFR 438.606 and must attest that, based on Contractor's best information, knowledge, and belief, the data, documentation, and information specified in 42 CFR 438.604 is accurate, complete, and truthful.
- C. In addition to Exhibit C, Provision 11. Certification Clauses, Contractor also agrees to the following:

With respect to any report, invoice, record, papers, documents, books of account, or other Contract required data submitted, pursuant to the requirements of this Contract, the Contractor's Representative or his/her designee will certify, under penalty of perjury, that the report, invoice,

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record, papers, documents, books of account or other Contract required data is current, accurate, complete and in full compliance with legal and contractual requirements to the best of that individual's knowledge and belief, unless the requirement for such certification is expressly waived by DHCS in writing.

10. Notices

A. All Notices

All notices to be given under this Contract will be in writing and will be deemed to have been given when mailed to DHCS or the Contractor:

California Department of
Health Care Services
Managed Care Operations Division
Attn: Contracting Officer
MS 4407
P.O. Box 997413
Sacramento, CA 95899-7413



B. Notification of Intent Not to Renew

If Contractor is a Local Initiative, should either DHCS or the Local Initiative elect not to renew this Contract, this decision will be conveyed in writing to the other party at least 12 months prior to the expiration of this Contract.

11. Term

A. The Contract will become effective [redacted] and will continue in full force and effect through [redacted] subject to the provisions of Exhibit B, Provision 1. Budget Contingency Clause, the Centers for Medicare and Medicaid Services waiver approval, and Exhibit D(F), Provision 3. Federal Contract Funds.

B. If the Contractor has not already begun Operations, the term of the Contract consists of the following three periods: 1) The Implementation Period; 2) The Operations Period shall commence at the conclusion of the Implementation Period, subject to DHCS acceptance of the Contractor's readiness to begin the Operations Period. The term of the Operations Period is subject to the termination provisions of Provision 14, Termination, and Provision 16, Sanctions, and subject to the limitation provisions of Exhibit B, Provision 1, Budget Contingency Clause; and 3) The Phaseout Period shall extend for six (6) months from the end of the Operations Period, subject to Provision 13, Contract Extension, in which case the Phaseout Period shall apply to the six (6) month period beginning with the first day after the end of the Operations Period, as extended.

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- C. If Contractor has begun Operations as of the effective date of this Contract, the term of the Contract consists of the Operations Period and the Phaseout Period. The Term of the Operations Period is subject to the termination provisions of Provision 14, Termination, and Provision 16, Sanctions, below and subject to the limitation provisions of Exhibit B, Provision 1, Budget Contingency Clause. The Phaseout Period shall extend for six (6) months from the end of the Operations Period, subject to Provision 13, Contract Extension, below, in which case the Phaseout Period shall apply to the six (6) month period beginning with the first day after the end of the Operations Period, as extended.

12. Service Area

The Service Area covered under this Contract includes:

 Counties

All Contract provisions apply separately to each Service Area. This Contract may expire for some Service Areas and still remain in effect for others with each Service Area having its own Operations and Phaseout periods.

13. Contract Extension

DHCS will have the exclusive option to extend the term of the Contract for any Service Area during the last twelve (12) months of the Contract, as determined by the original expiration date or by a new expiration date if an extension option has been exercised. DHCS may invoke up to five (5) separate extensions of up to twelve months each. The Contractor will be given at least nine (9) months prior written notice of DHCS' decision on whether or not it will exercise this option to extend the Contract for each Service Area.

Contractor will provide written notification to DHCS of its intent to accept or reject the extension within five (5) working days of the receipt of the notice from DHCS.

14. Termination for Cause and Other Terminations

In addition to Exhibit C, Provision 7. Termination for Cause, Contractor also agrees to the following:

- A. Termination - State or Director

DHCS may terminate performance of work under this Contract in whole, or in part, whenever for any reason DHCS determines that the termination is in the best interest of the State.

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- 1) Notification shall be given at least six (6) months prior to the effective date of termination, except in cases described below in Paragraph B. Termination for Cause.
- 2) If DHCS awards a new contract for one or more of the Service Areas to another Contractor during one of the amendment periods as described above in Provision 13. Contract Extension, DHCS shall provide the Contractor written notification at least six (6) months prior to termination to allow for all Phaseout Requirements to be completed.

B. Termination for Cause

- 1) DHCS shall terminate this Contract pursuant to the provisions of Welfare and Institutions Code, Section 14304(a) and Title 22 CCR Section 53873.
- 2) DHCS shall terminate this Contract in the event that: (1) the Secretary, DHHS, determines that the Contractor does not meet the requirements for participation in the Medicaid program, Title XIX of the Social Security Act (42 USC Section 1396), or (2) the Department of Managed Health Care finds that the Contractor no longer qualifies for licensure under the Knox-Keene Health Care Service Plan Act (Health and Safety Code Sections 1340 et seq.) by giving written notice to the Contractor. The termination will be effectuated consistent with the provisions of Title 22 CCR Section 53873. Notification will be given by DHCS at least 60 calendar days prior to the effective date of termination.
- 3) In cases where the Director determines the health and welfare of Members is jeopardized by continuation of the Contract, the Contract will be immediately terminated. Notification will state the effective date of, and the reason for, the termination.

Except for termination pursuant to Paragraph B, item 3) above, Contractor may dispute the termination decision through the dispute resolution process pursuant to Provision 18, Disputes. Termination of the Contract shall be effective on the last day of the month in which the Secretary, DHHS, or the DMHC makes such determination, provided that DHCS provides Contractor with at least 60 calendar days' notice of termination. The termination of this Contract shall be effective on the last day of the second full month from the date of the notice of termination. Contractor agrees that 60 calendar days' notice is reasonable. Termination under this section does not relieve Contractor of its obligations under Provision 15. Phaseout Requirements below. Phaseout Requirements shall be performed after Contract termination.

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C. Termination - Contractor

If mutual agreement between DHCS and Contractor cannot be attained on capitation rates for Rating Periods subsequent to September 30, 2005, Contractor shall retain the right to terminate the Contract, no earlier than September 30, 2006, by giving at least six (6) months written notice to DHCS to that effect. The effective date of any termination under this section shall be September 30.

Grounds under which Contractor may terminate this Contract are limited to: (1) Unwillingness to accept the capitation rates determined by DHCS, or if DHCS decides to negotiate rates, failure to reach mutual agreement on rates; or (2) When a change in contractual obligations is created by a State or Federal change in the Medi-Cal program, or a lawsuit, that substantially alters the financial assumptions and conditions under which the Contractor entered into this Contract, such that the Contractor can demonstrate to the satisfaction of DHCS that it cannot remain financially solvent through the term of the Contract.

If Contractor invokes ground number 2, Contractor shall submit a detailed written financial analysis to DHCS supporting its conclusions that it cannot remain financially solvent. At the request of DHCS, Contractor shall submit or otherwise make conveniently available to DHCS, all of Contractor's financial work papers, financial reports, financial books and other records, bank statements, computer records, and any other information required by DHCS to evaluate Contractor's financial analysis.

DHCS and Contractor may negotiate an earlier termination date if Contractor can demonstrate to the satisfaction of DHCS that it cannot remain financially solvent until the termination date that would otherwise be established under this section. Termination under these circumstances shall not relieve Contractor from performing the Phaseout Requirements described in Provision 15 below.

D. Termination of Obligations

All obligations to provide Covered Services under this Contract or Contract extension will automatically terminate on the date the Operations Period ends.

E. Notice to Members of Transfer of Care

At least 60 calendar days prior to the termination of the Contract, DHCS will notify Members about their medical benefits and available options.

15. Phaseout Requirements

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- A. DHCS shall retain the lesser of an amount equal to 10% of the last month's Service Area Capitation Payment or one million dollars (\$1,000,000) for each Service Area unless provided otherwise by the Financial Performance Guarantee, from the Capitation Payment of the last month of the operations period for each Service Area until all activities required during the phaseout period for each Service Area are fully completed to the satisfaction of DHCS, in its sole discretion.

If all phaseout activities for each Service Area are completed by the end of the phaseout period, the withhold will be paid to Contractor. If Contractor fails to meet any requirement(s) by the end of the phaseout period for each Service Area, DHCS will deduct the costs of the remaining activities from the withhold amount and continue to withhold payment until all activities are completed.

- B. The objective of the phaseout period is to ensure that, at the termination of this Contract, the orderly transfer of necessary data and history records is made from Contractor to DHCS or to a successor Contractor. Contractor shall not provide services to Members during the phaseout period.

90 calendar days prior to termination or expiration of this Contract and through the phaseout period for each Service Area, the Contractor shall assist DHCS in the transition of Members and in ensuring, to the extent possible, continuity of Member-Provider relationships. In doing this, the Contractor will make available to DHCS copies of Medical Records, patient files, and any other pertinent information, including information maintained by any Subcontractor or Network Provider, necessary for efficient case management of Members, as determined by the Director. In no circumstances will a Medi-Cal Member be billed for this activity.

- C. Phaseout for this Contract will consist of the processing, payment and monetary reconciliation(s) necessary regarding claims for payment for Covered Services.

Phaseout for this Contract will consist of the completion of all financial and reporting obligations of the Contractor. Contractor will remain liable for the processing and payment of invoices and other claims for payment for Covered Services and other services provided to Members pursuant to this Contract prior to the expiration or termination. Contractor will submit to DHCS all reports required in Exhibit A, Attachment 17, Reporting Requirements, for the period from the last submitted report through the expiration or termination date.

All data and information provided by Contractor will be accompanied by letter, signed by the responsible authority, certifying, under penalty of perjury, to the accuracy and completeness of the materials supplied.

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- D. Phaseout period will commence on the date the operations period of the Contract or Contract extension ends. Phaseout related activities are non-payable items.

16. Indemnification

- A. As a condition of entering into this Contract, Contractor agrees to indemnify, defend, and hold harmless the State, DHCS and its officers, agents, and employees from any and all claims and losses accruing or resulting from any and all Network Providers, Subcontractors, suppliers, laborers, and any other person, firm, or corporation furnishing or supplying work services, materials, or supplies in connection with the performance of this Contract, and from any and all claims and losses accruing or resulting to any person, firm or corporation who may be injured or damaged by Contractor in the performance of this Contract.
- B. Contractor further agrees to indemnify, defend, and hold harmless the State, DHCS and its officers, agents, and employees from any and all claims and losses, any and all attorneys' fees and costs, judgments, damages, and any administrative costs incurred by DHCS or a Member from any and all litigation, arbitration or mediation resulting directly, indirectly, or arising out of Contractor's denial, delay, or modification of requested covered health care services.
- C. Contractor further agrees to indemnify, defend, and hold harmless the State, DHCS and its officers, agents and employees from any and all claims and losses, any and all attorneys' fees and costs, including DHCS' defense costs, judgments, damages, any administrative costs incurred from claims that Contractor violated the Telephone Consumer Protection Act of 1991, 47 USC section 227 *et seq.*, and/or related Federal Communications Commission regulations in the performance of this Contract.
- D. Contractor further agrees to indemnify, defend and hold harmless the State, DHCS and its officers, agents and employees from any and all claims and losses, any and all attorneys' fees and costs, judgments, damages, any administrative costs incurred to the extent DHCS is required to provide notice to affected Members and Potential Enrollees, and any other costs associated with any actual or alleged breach of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (HIPAA), the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 (the HITECH Act"), 42 USC section 17921 *et seq.*, and their implementing privacy and security regulations at 45 CFR Parts 160 and 164, and the Information Practices Act, California Civil Code section 1798 *et seq.* by Contractor and any

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vendor, plan-to-plan contractors, Subcontractors and Network Providers that Contractor contracts with in the performance of this Contract.

- E. DHCS is authorized to withhold any and all attorneys' fees and costs, judgments, damages, any administrative costs incurred pursuant to this Indemnification agreement, from Contractor's next Capitation Payment or any other method to recoup DHCS costs from Contractor.

17. Sanctions

- A. Contractor is subject to sanctions and civil penalties for the specific conduct set forth in 42 CFR sections 438.700, 438.702, 438.704, 438.706 and 438.708. DHCS is also authorized to impose sanctions on Contractor pursuant to W&I Code section 14197.7.
- B. Monetary sanctions imposed pursuant to W&I Code section 14197.7 may be separately and independently assessed and may also be assessed for each day Contractor fails to correct an identified deficiency. For deficiencies that impact Members and Potential Enrollees, each Member impacted constitutes a separate violation for purposes of imposing a monetary sanction.
- C. Good cause for imposing monetary sanctions includes but is not limited to: A finding of deficiency that results in improper denial or delay in the delivery of health care services, potential endangerment to patient care, disruption in Contractor's Network, failure to approve continuity of care, claims that are accrued or will accrue and have not or will not be recompensed, or a delay in required Contractor reporting to DHCS.
- D. The Director may identify findings of noncompliance or good cause through any means, including, but not limited to: findings in audits, investigations, and contract compliance reviews; quality improvement system monitoring, routine monitoring, and Facility site surveys; Encounter Data and Provider data submissions; Network adequacy reviews, assessments of timely access requirements, and reviews of utilization data; Medi-Cal Managed Care Health Plan rating systems; Grievance, Appeals, State Fair Hearing decisions, and complaints from Members and other stakeholders, and whistleblowers; and Contractor's self-disclosures. DHCS is not required to impose a corrective action plan before imposing any of the sanctions set forth in this Provision.
- E. Sanctions in the form of denial of payments provided for under this Contract for new Members shall be taken, when and for as long as, payment for those Members is denied by the CMS under 42 CFR Section 438.730.

18. Liquidated Damages

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A. General

The Director shall have the authority to impose liquidated damages on Contractor for failure to comply with the terms of this Contract as well as all applicable Federal and State law or regulation. Therefore, it is agreed by the State and Contractor that:

- 1) If Contractor does not provide or perform the requirements of this Contract or applicable laws and regulations, damage to the State shall result,
 - a) Proving such damages shall be costly, difficult, and time-consuming,
 - b) Should the State choose to impose liquidated damages, Contractor shall pay the State those damages for not providing or performing the specified requirements,
 - c) Additional damages may occur in specified areas by prolonged periods in which Contractor does not provide or perform requirements,
 - d) The damage figures listed below represent a good faith effort to quantify the range of harm that could reasonably be anticipated at the time of the making of the Contract,
 - e) DHCS may, at its discretion, offset liquidated damages from Capitation Payment owed to Contractor;
- 2) Imposition of liquidated damages as specified in Paragraphs B, Liquidated Damages for Violation of Contract Terms Regarding the Implementation Period, and C, Liquidated Damages for Violation of Contract Terms or Regulations Regarding the Operations Period below shall follow the administrative processes described below.
- 3) Before imposing sanctions, DHCS shall provide Contractor with written notice specifying the nature of the sanctions and the Contractor requirement(s), contained in the Contract or as required by Federal and State law or regulation, not provided or performed,
- 4) During the Implementation Period, Contractor shall submit or complete the outstanding requirement(s) specified in the written notice within five (5) working days from the date of the notice, unless, subject to the Contracting Officer's written approval, Contractor submits a written request for an extension. The request must include the following: the requirement(s) requiring an

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extension; the reason for the delay and the proposed date of the submission of the requirement.

- 5) During the Implementation Period, if Contractor has not performed or completed an Implementation Period requirement or secured an extension for the submission of the outstanding requirement, DHCS may impose liquidated damages for the amount specified in Paragraph B. Liquidated Damages for Violation of Contract Terms Regarding the Implementation Period, below.
- 6) During the Operations Period, Contractor shall demonstrate the provision or performance of Contractor's requirement(s) specified in the written notice within a 30 calendar day Corrective Action period from the date of the notice, unless a request for an extension is submitted to the Contracting Officer, subject to DHCS' approval, within five (5) calendar days from the end of the Corrective Action period. If Contractor has not demonstrated the provision or performance of Contractor's requirement(s) specified in the written notice during the Corrective Action period, DHCS may impose liquidated damages for each day the specified Contractor's requirement is not performed or provided for the amount specified in Paragraph C. Liquidated Damages for Violation of Contract Terms or Regulations Regarding the Operations Period, below.
- 7) During the Operations Period, if Contractor has not performed or provided Contractor's requirement(s) specified in the written notice or secured the written approval for an extension, after 30 calendar days from the first day of the imposition of liquidated damages, DHCS shall notify Contractor in writing of the increase of the liquidated damages to the amount specified in Paragraph C. Liquidated Damages for Violation of Contract Terms or Regulations Regarding the Operations Period.

Nothing in this provision shall be construed as relieving Contractor from performing any other Contract duty not listed herein, nor is the State's right to enforce or to seek other remedies for failure to perform any other Contract duty hereby diminished.

B. Liquidated Damages for Violation of Contract Terms Regarding the Implementation Period, below.

DHCS may impose liquidated damages of \$25,000 per requirement specified in the written notice for each day of the delay in completion or submission of Implementation Period requirements beyond the Implementation Period as specified in Provision 11. Term, above.

If DHCS determines that a delay or other non-performance was caused in

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part by the State, DHCS will reduce the liquidated damages proportionately.

C. Liquidated Damages for Violation of Contract Terms or Regulations Regarding the Operations Period shall at a minimum include:

- 1) DHCS may impose liquidated damages of \$2,500 per day for each violation of Contract requirement not performed in accordance with Exhibit A, Attachment 4, Quality Improvement System, provision 10. Site Review, Paragraph D. Corrective Actions, until Contract requirement is performed or provided.
- 2) DHCS may impose liquidated damages of \$3,500 per instance or case, per Medi-Cal Member if a Contractor fails to deliver the requested information in accordance with Provision 23 Third-Party Tort Liability.
- 3) DHCS may impose liquidated damages of \$3,500 per violation of Contract requirement not performed in accordance with Exhibit A, Attachment 6, Provider Network, Provision 9. Plan Physician Availability.
- 4) DHCS may impose liquidated damages not to exceed \$10,000 per violation of this Contract's requirements, as well Federal and State law or regulation.

D. Conditions for Termination of Liquidated Damages

Except as waived by the Contracting Officer, no liquidated damages imposed on the Contractor will be terminated or suspended until the Contractor issues a written notice of correction to the Contracting Officer certifying, under penalty of perjury, the correction of condition(s) for which liquidated damages were imposed. Liquidated damages will cease on the day of the Contractor's certification only if subsequent verification of the correction by DHCS establishes that the correction has been made in the manner and at the time certified to by the Contractor.

The Contracting Officer will determine whether the necessary level of documentation has been submitted to verify corrections. The Contracting Officer will be the sole judge of the sufficiency and accuracy of any documentation. Corrections must be sustained for a reasonable period of at least 90 calendar days from DHCS acceptance; otherwise, liquidated damages may be reimposed without a succeeding grace period within which to correct. The Contractor's use of resources to correct deficiencies will not be allowed to cause other Contract compliance problems.

E. Severability of Individual Liquidated Damages Clauses

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If any portion of these liquidated damages provisions is determined to be unenforceable, the other portions will remain in full force and effect.

19. Contractor's Dispute Resolution Requirements

Contractor must comply with and exhaust the requirements of this section when it alleges a contract dispute with DHCS. This paragraph 18 does not apply to challenges to DHCS imposed sanctions, liquidated damages (which are governed by sections 16 and 17 respectively) or any other contract enforcement action initiated by DHCS. Contractor's filing of a Notice of Dispute, as defined in section B). 1) – 7) below, does not preclude DHCS from withholding or recouping the value of the amount in dispute from Contractor or from offsetting the amount in dispute from Contractor's Capitation Payment(s).

A. Resolution of Dispute by Negotiation

Contractor agrees to use its best efforts to resolve all alleged contractual disputes by negotiation and mutual agreement at the Contracting Officer level before filing an appeal with DHCS' Office of Administrative Hearings and Appeals (OAHA). Contractor must exhaust the OAHA appeal process before filing a writ in Sacramento Superior Court. During the negotiations to resolve Contractor's allegations, DHCS and Contractor may agree, in writing, to an extension of time for Contractor's submission of its Notice of Dispute defined in Section B.

B. Notice of Dispute

Within 30 calendar days of the date that the alleged dispute arises or otherwise becomes known to Contractor, Contractor must serve a written Notice of Dispute to its DHCS Contract Manager.

Contractor's Notice of Dispute must include, based on the most accurate information available to Contractor, the following:

- 1) That the dispute is subject to the procedures in this Provision.
- 2) The date, nature, and circumstances of the alleged conduct that is the subject of the dispute.
- 3) The names, phone numbers, functions, and conduct of each Contractor, Subcontractor, Network Provider, DHCS/State official or employee involved in or knowledgeable of the alleged conduct that is the subject of the dispute.
- 4) The identification of any documents and the substance of any oral communications that are relevant to the alleged dispute.

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- 5) Copies of all substantiating documents and any other evidence to its Notice of Dispute.
- 6) The factual and legal bases prompting Contractor's Notice of Dispute.
- 7) The cost impact to Contractor directly attributable to the alleged conduct, if any.
- 8) Contractor's desired remedy.

Any appeal of the Contracting Officer's decision to OAHA or a writ seeking review of OAHA's decision in Sacramento Superior Court is limited to the issues set forth in Contractor's Notice of Dispute and the substantiating documentation provided pursuant to Paragraphs B, and C.3, below.

After Contractor submits its Notice of Dispute with all available supporting documentation, Contractor must comply with 22 CCR section 53851(d) and diligently continue performance of its obligations under this Contract, including compliance with contract requirements that are the subject of, or related to, Contractor's Notice of Dispute.

If Contractor requests and the Contracting Officer agrees, Contractor's Notice of Dispute may be decided by an alternate dispute officer (ADO) for determination. DHCS may designate the ADO, who was not directly involved in the alleged conduct that prompted Contractor's Notice of Dispute.

C. Contracting Officer's or Alternate Dispute Officer's Decision

The Contracting Officer or ADO will have 60 days to review Contractor's initial Notice of Dispute and all substantiating documentation. If the Contracting Officer or ADO determine that additional substantiating documentation is required, Contractor must provide that additional substantiating documentation no later than 30 calendar days from the request.

Unless Contractor and the Contracting Officer or ADO agree to an extension of time, Contractor's failure to provide additional substantiating documentation, within 30 calendar days from the request, constitutes Contractor's waiver of all claims set forth in Contractor's Notice of Dispute in accordance with F). Waiver of Claims, below.

Issues raised by Contractor in the Notice of Dispute will be decided by the Contracting Officer or the ADO Within 30 calendar days from receipt of all

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substantiating documentation and additionally requested substantiating documentation, the Contracting Officer or the ADO, will:

- 1) Find in favor of Contractor, in which case the Contracting Officer or ADO may:
 - a) Correct the conduct which prompted Contractor's Notice of Dispute; or
 - b) Reaffirm the conduct and, if there is a cost impact sufficient to constitute a change in obligations pursuant to the payment provisions contained in Exhibit B Budget Detail and Payment Provisions, direct DHCS to comply with that Exhibit.
- 2) Deny Contractor's Notice of Dispute and, where necessary, direct the manner of Contractor's future contractual performance; or
- 3) The time limits in this subparagraph C may be extended by the Contracting Officer or Alternate Dispute Officer for up to 60 additional days upon request of Contractor and/or if it is necessary to allow the Contracting Officer or Alternate Dispute Officer to consider the dispute and/or substantiating documentation.
- 4) Contractor shall have 30 calendar days to respond to the Contracting Officer's or ADO's request for additional substantiating documentation and other necessary evidence. Upon receipt of this additional requested substantiating documentation, the Contracting Officer or ADO shall have 60 calendar days to respond with a decision. Contractor's failure to provide all additional substantiating documentation and other evidence requested by the Contracting Officer or ADO within 30 calendar days shall constitute waiver by Contractor of all claims in accordance with Paragraph F. Waiver of Claims, below.

D. Appeal of Contracting Officer's or Alternate Dispute Officer's Decision

- 1) Contractor shall have 30 calendar days from receipt of Contracting Officer's or ADO's decision to appeal the decision to the Director through OAHA. All appeals shall be governed by Health and Safety Code Section 100171, except Government Code section 11511 relating to depositions will not apply. The venue for all OAHA appeals is Sacramento.
- 2) All appeals must be in writing and must be filed with OAHA with a copy sent to the Chief Counsel of DHCS and the Contract Manager. An appeal shall be deemed filed on the date it is received by OAHA. An appeal shall specifically set forth each issue in

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dispute, including Contractor's contentions as to each issue. However, Contractor's appeal is solely limited to the issues raised in its Notification of Dispute filed pursuant to Paragraph B. Notification of Dispute, above.

- 3) Contractor has the burdens of proof and its evidence is limited to the substantiating documentation it produced to the Contracting Officer or ADO. Contractor must show by a preponderance of evidence that:
 - a) DHCS acted improperly such that it breached this contract; and,
 - b) That Contractor sustained a cost impact directly related to DHCS' breach.
- 4) OAHA's jurisdiction is limited to issues raised in the Notice of Dispute that were not waived by Contractor's failure to provide all requested substantiating documentation required by the Contracting Officer's or ADO.
- 5) Contractor's failure to timely appeal the decision to OAHA shall constitute a waiver by Contractor of all claims arising out of the alleged conduct that prompted Contractor's Notice of Dispute, in accordance with Paragraph F, Waiver of Claims below.

E. Contractor's Duty to Perform

Contractor must comply with all requirements of 22 CCR section 53851(d) and all obligations under this Contract, including continuing contract obligations that are the subject of, or related to, Contractor's Notice of Dispute until there is a final decision from the Contracting Officer or the ADO.

If Contractor appeals the Contracting Officer's or ADO's decision pursuant to Paragraph D, Appeal of Contracting Officer's or ADO's Decision above, and Contracting Officer's or ADO's decision is reversed, DHCS shall not be required to pay interest on any underpayment found due and owing pursuant to the Notice of Dispute.

F. Waiver of Claims

Contractor waives all claims or issues if it fails to timely submit a Notice of Dispute with all substantiating documentation. Contractor also waives all claims or issues set forth in its Notice of Dispute if it fails to timely submit all additional substantiating documentation within 30 days of the Contracting Officer's or ADO's request, or if it fails to timely appeal the

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Contracting Officer's or ADO's decision in the manner and within the time specified in this Provision 18. Contractor's waiver includes all damages whether direct or consequential in nature.

20. Audit

In addition to Exhibit C, Provision 4, Audit, Contractor also agrees to the following:

Pursuant to 42 CFR 438.3(h), DHCS, CMS, the DHHS Office of the Inspector General, the Comptroller General, and their designees may, at any time, inspect and audit any of Contractor's, or its Subcontractors' and Network Providers', records or documents and may, at any time, inspect the premises, physical facilities, and equipment where Medi-Cal-related activities or work is conducted. The right to audit under this Section exists for ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later.

Contractor will maintain such records and documents necessary to disclose how Contractor discharged its obligations under this Contract. These records and documents will disclose the quantity of Covered Services provided under this Contract, the quality of those services, the manner and amount of payment made for those services, the persons eligible to receive Covered Services, the manner in which Contractor administered its daily business, and the cost thereof.

A. Records and Documents

These records and documents will include, but are not limited to, all physical books or records originated or prepared pursuant to the performance under this Contract including working papers; reports submitted to DHCS; financial records; all medical records, medical charts and prescription files; and other documentation pertaining to medical and non-medical services rendered to Members.

B. Records Retention

Notwithstanding any other records retention time period set forth in this Contract, Contractor, and all of its Subcontractors and Network Providers, shall maintain all of these records and documents for a minimum of ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later.

C. Additional Recordkeeping Requirements

- 1) In accordance with 42 CFR 438.3(u), Contractor shall retain the following information for no less than 10 years:

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- a) Member Grievance and Appeal records as required in 42 CFR 438.416;
 - b) Base data as defined in 42 CFR 438.5(c);
 - c) MLR reports as required in 42 CFR 438.8(k); and
 - d) Data, information, and documentation specified in 42 CFR 438.604, 606, 608, and 610.
- 2) Contractor shall also require Subcontractors and Network Providers to be compliant, as applicable, with 42 CFR 438.3(u).

21. Inspection Rights

In addition to Exhibit D(F), Provision 2, Site Inspection, Contractor also agrees to the following:

Through the end of the records retention period specified in Provision 19, Audit, Paragraph B, Records Retention above, Contractor shall allow the DHCS, the DHHS Office of the Inspector General, the Comptroller General of the United States, the DOJ Bureau of Medi-Cal Fraud, DMHC, and other authorized State agencies, or their duly authorized representatives or designees, including DHCS' EQRO contractor, to audit, inspect, monitor or otherwise evaluate the quality, appropriateness, and timeliness of services performed under this Contract, and to inspect, evaluate, and audit any and all premises, books, records, equipment, facilities, contracts, computers, or other electronic systems maintained by Contractor, Subcontractors, and Network Providers pertaining to these services at any time, pursuant to 42 CFR 438.3(h).

Records and documents include, but are not limited to, all physical records originated or prepared pursuant to the performance under this Contract, including working papers, reports, financial records, and books of account, medical records, prescription files, laboratory results, Subcontractor Agreements and Network Provider Agreements, information systems and procedures, and any other documentation pertaining to medical and non-medical services rendered to Members. Upon request, through the end of the records retention period specified in Provision 19, Audit, Paragraph B, Records Retention above, Contractor shall furnish any record, or copy of it, to DHCS or any other entity listed in this section, at Contractor's sole expense.

If DHCS, CMS, or the DHHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit a Subcontractor or Network Provider at any time.

A. Facility Inspections

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DHCS shall conduct unannounced validation reviews on a number of the Contractor's primary care sites, selected at DHCS' discretion, to verify compliance of these sites with DHCS requirements.

B. Access Requirements and State's Right to Monitor

Authorized State and federal agencies will have the right to monitor all aspects of the Contractor's operation for compliance with the provisions of this Contract and applicable Federal and State laws and regulations. Such monitoring activities will include, but are not limited to, inspection and auditing of Contractor, Subcontractor, Network Provider, and Provider facilities, management systems and procedures, and books and records as the Director deems appropriate, at any time, pursuant to 42 CFR 438.3(h). The monitoring activities will be either announced or unannounced.

To assure compliance with the Contract and for any other reasonable purpose, the State and its authorized representatives and designees will have the right to premises access, with or without notice to Contractor. This will include the MIS operations site or such other place where duties under the Contract are being performed.

Staff designated by authorized State agencies will have access to all security areas and Contractor will provide, and will require any and all of its Subcontractors and Network Providers to provide, reasonable facilities, cooperation and assistance to State representative(s) in the performance of their duties. Access will be undertaken in such a manner as to not unduly delay the work of Contractor and/or the Subcontractor(s) and Network Provider(s).

22. Confidentiality of Information

In addition to Exhibit D(F), Provision 4, Confidentiality of Information, Contractor also agrees to the following duties and responsibilities with respect to confidentiality of information and data:

- A. Notwithstanding any other provision of this Contract, names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with 42 CFR Section 431.300 et seq., W&I Code Section 14100.2, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by the Contractor from unauthorized disclosure.

Contractor may release Medical Records in accordance with applicable

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law pertaining to the release of this type of information. Contractor is not required to report requests for Medical Records made in accordance with applicable law.

- B. With respect to any identifiable information concerning a Member under this Contract that is obtained by the Contractor or its Subcontractors or Network Providers, Contractor will:
- 1) Not use any such information for any purpose other than carrying out the express terms of this Contract;
 - 2) Promptly transmit to DHCS all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law;
 - 3) Not disclose except as otherwise specifically permitted by this Contract, any such information to any party other than DHCS without DHCS' prior written authorization specifying that the information is releasable under Title 42, CFR, Section 431.300 et seq., W&I Cod Section 14100.2, and regulations adopted thereunder; and
 - 4) At the termination of this Contract, return all such information to DHCS or maintain such information according to written procedures sent to Contractor by DHCS for this purpose.

23. Pilot Projects

DHCS may establish pilot projects to test alternative managed care models tailored to suit the needs of populations with special health care needs. The operation of these pilot projects may result in the disenrollment of Members that participate. Implementation of a pilot project may affect Contractor's obligations under this Contract. Any changes in the obligations of Contractor that are necessary for the operation of a pilot project in Contractor's Service Area will be implemented through a contract amendment.

24. Cost Avoidance and Post-Payment Recovery (PPR) of Other Health Coverage (OHC)

- A. Contractor shall Cost Avoid or make a PPR for the reasonable value of services paid by Contractor and rendered to a Member whenever a Member's OHC covers the same services, fully or partially. However, in no event shall Contractor Cost Avoid or seek PPR for the reasonable value of services from a Third-Party Tort Liability (TPTL) action or make a claim against the estates of deceased Members.

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- B. Contractor shall rely on the Medi-Cal eligibility record for Cost Avoidance and PPR purposes.
- C. Contractor retains all monies for PPR when Contractor initiates and completed recovery within 12 months from the date of payment of a service. Any monies for PPR obtained after the 12 months following the date of payment of a service are considered Medi-Cal recoveries and shall be remitted to DHCS.
- D. If Contractor initiates an active repayment plan with Network Providers or third party insurance carriers that is agreed upon prior to, and extends beyond 12 months from, the date of payment of a service, Contractor will be allowed to retain the recovered monies.
- E. Contractor shall coordinate benefits with other coverage programs and entitlements, recognizing the OHC as primary and the Medi-Cal program as the payer of last resort, except for services in which Medi-Cal is required to be the primary payer.
- F. Contractor shall conduct Post-Payment Recovery using the threshold guidelines as described in State Plan Amendment 4.22-B.
- G. Cost Avoidance
 - 1) Contractor shall not pay claims for services provided to a Member whose Medi-Cal eligibility record indicates third party coverage, designated by an OHC code or Medicare coverage, without proof that Provider has first exhausted all sources of other payments.
 - 2) Acceptable forms of proof that all sources of payment have been exhausted or do not apply include a denial letter from the OHC for the service, an explanation of benefits indicating that the service is not covered by the OHC, or documentation demonstrating that the Provider has billed the OHC and received no response for at least 90 days.
 - 3) Contractor shall ensure that Providers do not refuse to provide Covered Services to Members, when OHC is indicated on a Member's Medi-Cal eligibility record.
 - 4) Contractor shall allow Providers to directly bill services that meet DHCS requirements for direct billing without attempting to Cost Avoid those services. Cost Avoidance is not required prior to payment for services provided to Members with OHC codes A or N. More information on services that qualify for direct billing can be found in the Medi-Cal Provider Manual, Part 2 – General Medicine, section “Other Health Coverage (OHC): CPT-4 and HCPCS Codes

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- 5) Prior to delivering services, Contractor shall ensure that Providers review the Member's Medi-Cal eligibility record for third party coverage, designated by OHC or Medicare coverage code. If the Member's Medi-Cal eligibility record indicates OHC and the requested service is covered by OHC, Contractor shall ensure that Providers notify the Member to seek the service from OHC.
- 6) When Contractor denies a claim due to OHC, Contractor shall include OHC information in its notice of claim denial to Provider. OHC information includes, but is not limited to, the name of the OHC or Medicare carrier, and contact or billing information of the OHC.

H. Reporting Requirements for Cost Avoidance

Contractor shall report new OHC information not found on the Medi-Cal eligibility record or that is different from what is reflected on the Medi-Cal eligibility record to DHCS within ten (10) calendar days of discovery. Contractor shall report discrepancies in the Medi-Cal record by completing and submitting either an OHC removal or addition form found online at <http://dhcs.ca.gov/OHC>, or reporting OHC information to DHCS in batch updates. Batch updates regarding OHC information are processed by DHCS on a weekly basis. Contractor may contact their Managed Care Operations Division (MCOD) contract manager for more information regarding this process.

I. Post-Payment Recovery

- 1) Contractor shall pay the Provider's claim and then seek to recover the cost of the claim by billing the liable third parties in either of the following circumstances:
 - a) For services provided to Members with OHC code A; or
 - b) For services defined by DHCS as preventive pediatric services.
- 2) When Contractor discovers that a service was provided to a Member with OHC designated in the Medi-Cal eligibility record, and Contractor did not properly Cost Avoid the service, then Contractor shall bill the OHC for the cost of actual services rendered. If OHC is discovered retroactively, Contractor shall also bill the OHC for the cost of actual services rendered.
- 3) Contractor shall bill the liable OHC for the cost of services provided

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to Members. Billing and recoupment shall be completed within 12 months from the date of payment of a service.

- 4) Monies recovered by DHCS or a DHCS contracted recovery agent starting on the first day of the 13th month after the date of payment of a service will be retained by DHCS unless Contractor has an active repayment agreement as described in Paragraph D above.

J. Reporting Requirements

Contractor shall submit a monthly PPR Report to DHCS via secure file transfer protocol by the 15th day of each month in a format specified by DHCS in applicable APL(s). This report shall contain claims and recovery information and any other information specified by DHCS in applicable APL(s).

- K. Contractor shall have written policies and procedures implementing all of the requirements of this provision.

25. Third-Party Tort and Worker's Compensation Liability

Contractor shall not make a claim for recovery of the value of Covered Services rendered to a Member in cases or instances involving casualty insurance, tort, Worker's Compensation, or class action claims. Contractor's failure to comply with this Provision is non-delegable. In the event that Contractor's failure to comply with this Provision negatively impacts DHCS' ability to recover its full statutory lien, DHCS reserves the right to deduct any losses from Contractor's Capitation Payments. To assist DHCS in exercising DHCS' exclusive responsibility for recovering casualty insurance, tort, Worker's Compensation, or class action claims, Contractor shall:

- A. Within 30 days of DHCS' request, submit all requested service and utilization information and, when requested, copies of paid invoices/claims for its Members, including information from Network Providers, Out-of-Network Providers, and Subcontractors. Service and utilization information and copies of paid invoices/claims shall set out any services provided by Contractor, including, but not limited to, physical, mental, and dental health services. Records shall include services provided on a FFS, capitated basis, or any other payment arrangements, regardless of whether a payment was made or denied. The reasonable value of the services shall be calculated as the usual, customary and reasonable charge made to the general public for similar services or the amount paid to Network Providers or Out-of-Network Providers for similar services. No additional payment will be made to Contractor for compliance with this Provision.
- B. Submit the requested service and utilization information and paid

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invoices/claims in a form and manner specified by DHCS via DHCS' designated secure file transfer protocol (SFTP) site, in compliance with the electronic format and process as set forth in applicable APL(s). Contractor shall include the attestation in a form and manner specified by DHCS signed by the custodian of records or a designee with knowledge of the Member information provided to DHCS, as specified in applicable APL(s).

- C. Notify DHCS using the appropriate online notification form at <https://dhcs.ca.gov/PIForms> within ten (10) days of receiving a request from attorneys, insurers, or Members for a lien, pursuant to DHCS' recovery rights. These requirements do not relieve Contractor of other legal duties to Members or other entities, including, without limitation, the duty to respond to Members' requests for their own Protected Health Information (PHI) pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- D. Use the TPLManagedCare@dhcs.ca.gov inbox for all communications regarding Contractor's service and utilization information and copies of paid invoices/claims file submissions, to submit questions or comments related to the preparation and submission of these reports, and for issues related to accessing the SFTP folders.
- E. Have written policies and procedures implementing all of the requirements of this provision.

26. Records Related To Recovery for Litigation

A. Records

Upon request by DHCS, Contractor shall timely gather, preserve and provide to DHCS, in the form and manner specified by DHCS, any information specified by DHCS, subject to any lawful privileges, in Contractor's or its Subcontractors' or Network Provider's possession, relating to threatened or pending litigation by or against DHCS. (If Contractor asserts that any requested documents are covered by a privilege, Contractor shall:

- 1) Identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and
- 2) State the privilege being claimed that supports withholding production of the document.

Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against DHCS. Contractor acknowledges that time may be of the essence in responding to such request. Contractor shall use all reasonable efforts to immediately

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notify DHCS of any subpoenas, document production requests, or requests for records, received by Contractor or its Subcontractors or Network Providers related to this Contract or Subcontractor Agreements and Network Provider Agreements entered into under this Contract.

B. Payment for Records

In addition to the payments provided for in Exhibit B, Budget Detail and Payment Provisions, DHCS agrees to pay Contractor for complying with Paragraph A, Records, above, as follows:

- 1) DHCS shall reimburse Contractor amounts paid by Contractor to third parties for services necessary to comply with Paragraph A. Any third party assisting Contractor with compliance with Paragraph A above, shall comply with all applicable confidentiality requirements. Amounts paid by Contractor to any third party for assisting Contractor in complying with Paragraph A, shall not exceed normal and customary charges for similar services and such charges and supporting documentation shall be subject to review by DHCS.
- 2) If Contractor uses existing personnel and resources to comply with Paragraph A, DHCS shall reimburse Contractor as specified below. Contractor shall maintain and provide to DHCS time reports supporting the time spent by each employee as a condition of reimbursement. Reimbursement claims and supporting documentation shall be subject to review by DHCS.
 - a) Compensation and payroll taxes and benefits, on a prorated basis, for the employees' time devoted directly to compiling information pursuant to Paragraph A.
 - b) Costs for copies of all documentation submitted to DHCS pursuant to Paragraph A, subject to a maximum reimbursement of ten (10) cents per copied page.
- 3) Contractor shall submit to DHCS all information needed by DHCS to determine reimbursement to Contractor under this provision, including, but not limited to, copies of invoices from third parties and payroll records.

27. Fraud, Waste, and Abuse Reporting

- A. For purposes of this Exhibit, the following definitions apply:

Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the

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Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program (42 CFR 455.2 and as further defined in W. & I. Code Section 14043.1(a).)

Conviction or Convicted means that a judgment of conviction has been entered by a federal, State, or local court, regardless of whether an appeal from that judgment is pending (42 CFR 455.2). This definition also includes the definition of the term “convicted” in W & I Code Section 14043.1(f).

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or State law (42 CFR 455.2; W. & I. Code Section 14043.1(i).)

Waste means the overutilization or inappropriate utilization of services and misuse of resources, and typically is not a criminal or intentional act, as stated in CMS’ Fraud, Waste, and Abuse Toolkit.

- B. Contractor shall meet the requirements set forth in 42 CFR section 438.608 by establishing administrative and management arrangements or procedures, as well as a mandatory compliance plan, which are designed to guard against fraud, waste, and abuse. These requirements shall be met through the following:
- 1) Contractor and its Subcontractor or Network Provider, to the extent that its Subcontractor or Network Provider is delegated responsibility by Contractor for coverage of services and payment of claims under this Contract, shall implement and maintain procedures that are designed to detect and prevent Fraud, Waste, and Abuse. The procedures must include a compliance program, as set forth in 42 CFR 438.608(a), that at a minimum includes all of the following elements:
 - a) Written policies and procedures that articulate a commitment to comply with all applicable requirements and standards under this Contract, and all applicable federal and State requirements.
 - b) The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of this Contract, and who reports directly to the Chief Executive Officer and the Board of Directors.

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- c) The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the compliance program and compliance with the requirements under this Contract.
 - d) A system for training and educating the Compliance Officer, senior management, and employees on federal and State standards and requirements of this Contract.
 - e) Effective lines of communication between the Compliance Officer and employees.
 - f) Enforcement of standards through well-publicized disciplinary guidelines.
 - g) Establishment and implementation of a system with dedicated staff for: routine internal monitoring and auditing of compliance risks; promptly responding to compliance issues as they are raised; investigation of potential compliance problems as identified in the course of self-evaluation and audits; correction of such problems promptly and thoroughly, or coordination of suspected criminal acts with law enforcement agencies to reduce the potential for recurrence; and ongoing compliance with the requirements under this Contract.
- 2) Prompt reporting, within ten (10) Working Days to DHCS of all Overpayments identified or recovered, specifying which Overpayments are due to potential fraud.
 - 3) Prompt notification, within ten (10) Working Days to DHCS when Contractor receives information about changes in a Member's circumstances that may affect the Member's eligibility including the following:
 - a) Changes in the Member's residence;
 - b) Changes in the Member's income; and
 - c) The death of a Member.
 - 4) Prompt notification, within ten (10) Working Days to DHCS when Contractor receives information about a change in a Network Provider's circumstances that may affect the Network Provider's eligibility to participate in the Medi-Cal managed care program, including the termination of their Provider agreement with

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- 5) Provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by Network Providers were received by Members, and the application of this verification processes on a regular basis.
- 6) When Contractor makes or receives annual payments under this Contract of at least \$5,000,000, provide written policies for all of its employees, and for any Subcontractor, Network Provider or agent, that provides detailed information about the False Claims Act and other federal and State laws described in Section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers.
- 7) Fraud, Waste, and Abuse Reporting

Prompt referral of any potential Fraud, Waste, or Abuse that Contractor identifies to the DHCS Audits and Investigations Intake Unit. Contractor shall conduct, complete, and report to DHCS, the results of a preliminary investigation of the suspected fraud and/or abuse within ten (10) Working Days of the date Contractor first becomes aware of, or is on notice of, such activity.

Fraud reports submitted to DHCS must, at a minimum, include:

- a) Number of complaints of fraud and abuse submitted that warranted preliminary investigation.
- b) For each complaint which warranted a preliminary investigations, supply:
 - i. Name and/or SSN or CIN;
 - ii. Source of complaint;
 - iii. Type of Provider (if applicable);
 - iv. Nature of complaint;
 - v. Approximate dollars involved; and
 - vi. Legal and administrative disposition of the case.

The report shall be submitted on a Confidential Medi-Cal Complaint Report (MC 609) that can be sent to DHCS in one of three ways:

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- a) Email at PIU.Cases@DHCS.ca.gov;
- b) E-fax at (916) 440-5287; or
- c) U.S. Mail at:

Department of Health Care Services
Audits & Investigations Division
Attention: Chief, Intake Unit
1500 Capitol Avenue
MS 2500
Sacramento, CA 95814

Contractor shall submit the following components with the report or explain why the components are not submitted with the report: police report, health plan's documentation (background information, investigation report, interviews, and any additional investigative information), Member information (patient history chart, Patient profile, Claims detail report), Provider enrollment data, Confirmation of services, list items or services furnished by the Provider, Pharmaceutical data from manufacturers, wholesalers and retailers and any other pertinent information.

8) Tracking Suspended Providers

Contractor shall comply with 42 CFR 438.608(a)(8) and 438.610. Additionally, Contractor and its Subcontractors are prohibited from employing, paying, contracting or maintaining a contract with physicians or other health care providers that are excluded, suspended or terminated from participation in the Medicare or Medi-Cal/Medicaid programs. A list of suspended and ineligible providers is maintained in the Medi-Cal Provider Manual, which is updated monthly and available on line and in print at the DHCS Medi-Cal Web site (<http://www.medi-cal.ca.gov>) and by the Department of Health and Human Services, Office of Inspector General, List of Excluded Individuals and Entities (<http://oig.hhs.gov>). Contractor is deemed to have knowledge of any providers on these lists. Contractor must notify the Medi-Cal Managed Care Program/Program Integrity Unit within ten (10) Working Days of removing a suspended, excluded, or terminated provider from its Provider Network and confirm that the Provider is no longer receiving payments in connection with the Medicaid program. A removed, suspended, excluded, or terminated provider report can be sent to DHCS in one of three (3) ways:

- a) Email at PIUCases@DHCS.ca.gov;

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- b) E-fax at (916) 440-5287; or
- c) U.S. Mail at:

Department of Health Care Services
Managed Care Operations Division
Attention: Chief, Program Integrity Unit
MS 4417
P.O. Box 997413
Sacramento, CA 95899-7413

C. Federal False Claim Act Compliance

Contractor shall comply with 42 USC Section 1396a(a)(68), Employee Education About False Claims Recovery, as a condition of receiving payments under this Contract. Upon request by DHCS, Contractor shall demonstrate compliance with this Provision, which may include providing DHCS with copies of Contractor's applicable written policies and procedures and any relevant employee handbook excerpts.

28. Equal Opportunity Employer

Contractor must comply with all applicable federal and State employment discrimination laws. Contractor will, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, state that it is an equal opportunity employer, and will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding, a notice to be provided by DHCS, advising the labor union or workers' representative of the Contractor's commitment as an equal opportunity employer and will post copies of the notice in conspicuous places available to employees and applicants for employment.

29. Discrimination Prohibitions

A. Member Discrimination Prohibition

Contractor shall not unlawfully discriminate against Members or Eligible Beneficiaries on the basis of any ground protected under federal or state nondiscrimination law, including because of sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code 422.56, in accordance with the statutes identified in Exhibit E, Attachment 2, Provision 28 below, rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulations. For the purpose of this Contract, may

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include, but is not limited to, the following:

- 1) Denying any Member any Covered Services or availability of a Facility;
- 2) Providing to a Member any Covered Service which is different, or is provided in a different manner or at a different time from that provided to other Members under this Contract except where medically indicated;
- 3) Subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service;
- 4) Restricting a Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service, treating a Member or Eligible Beneficiary differently from others in determining whether he or she satisfies any admission, Enrollment, quota, eligibility, membership, or other requirement or condition which individuals must meet in order to be provided any Covered Service;
- 5) The assignment of times or places for the provision of services on the basis of the sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation or identification with any other persons or groups defined in Penal Code 422.56, of the participants to be served;
- 6) Failing to make Auxiliary Aids available, or to make reasonable accommodations in policies, practices, or procedures, when necessary to avoid discrimination on the basis of disability;
- 7) Failing to ensure meaningful access to programs and activities for Limited English Proficient (LEP) Members and Potential Enrollees.

Contractor shall take affirmative action to ensure that Members are provided Covered Services without regard to sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code 422.56, except as needed to provide equal access to LEP Members or Members with disabilities, or as medically indicated. For the purposes of this section, physical handicap includes the carrying of a gene which may, under some circumstances, be associated with disability in that person's

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offspring, but which causes no adverse effects on the carrier. Such genes will include, but are not limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

B. Discrimination Related To Health Status

Contractor shall not discriminate among eligible individuals on the basis of their health status requirements or requirements for health care services during enrollment, re-enrollment or disenrollment. Contractor will not terminate the enrollment of an eligible individual based on an adverse change in the Member's health.

30. Federal and State Nondiscrimination Requirements

Contractor shall comply with all applicable federal requirements in Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities, as amended); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973, as amended; Titles I and II of the Americans with Disabilities Act of 1990, as amended; and Section 1557 of the Patient Protection and Affordable Care Act of 2010; and federal implementing regulations issued under the above-listed statutes. Contractor shall also comply with California nondiscrimination requirements, including, without limitation, the Unruh Civil Rights Act, Government Code Sections 7405 and 11135, W&I Code Section 14029.91, and State implementing regulations.

31. Disabled Veteran Business Enterprises (DVBE)

Contractor shall comply with applicable requirements of California law relating to Disabled Veteran Business Enterprises (DVBE) commencing at Section 10115 of the Public Contract Code.

32. Word Usage

Unless the context of this Contract clearly requires otherwise, (a) the plural and singular numbers shall each be deemed to include the other; (b) the masculine, feminine, and neuter genders shall each be deemed to include the others; (c) "shall," "will," "must," or "agrees" are mandatory, and "may" is permissive; (d) "or" is not exclusive; and (e) "includes" and "including" are not limiting.

33. Federal False Claims Act Compliance

Effective January 1, 2007, Contractor shall comply with 42USC Section 1396a(a)(68), Employee Education About False Claims Recovery, as a condition of receiving payments under this Contract. Upon request by DHCS, Contractor shall demonstrate compliance with this provision, which may include providing DHCS with copies of Contractor's applicable written policies and procedures and any relevant employee handbook excerpts.

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34. Disclosures

In accordance with 42 CFR 438.608(c), Contractor and any Subcontractors shall:

- A. Provide written disclosure of any prohibited affiliation under 42 CFR 438.610.
- B. Provide written disclosures of information on ownership and control as required under 42 CFR 455.104.
- C. Report to DHCS within 60 calendar days when it has identified the Capitation Payments or other payments in excess of the amounts specified in this Contract.

35. Treatment of Recoveries

- A. Per 42 CFR 438.608(d)(1) relating to the treatment of recoveries made by Contractor of Overpayments to Providers, Contractor shall comply with guidelines issued by DHCS pertaining to:
 - 1) The retention policies for the treatment of recoveries of all Overpayments from Contractor to a Provider, including for the treatment of recoveries of Overpayments due to Fraud, Waste, or Abuse.
 - 2) The process, timeframes, and documentation required for reporting the recovery of all Overpayments.
 - 3) The process, timeframes, and documentation required to pay recoveries of Overpayments to DHCS when Contractor is not permitted to retain some or all of the recoveries of Overpayments.
 - 4) This Provision does not apply to any amount of a recovery to be retained under the False Claims Act cases or through other investigations.
- B. Contractor shall require and have a mechanism in place for a Network Provider to report to Contractor when it has received an Overpayment, to return the Overpayment to Contractor within 60 calendar days after the date the Overpayment was identified, and to notify Contractor in writing of the reason for the Overpayment, per 42 CFR 438.608(d)(2).
- C. Contractor shall annually report to DHCS their recoveries of Overpayments per 42 CFR 438.608(d)(3).
- D. In accordance with 42 CFR 438.608(d)(4), DHCS shall use the results of

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the information and documentation collected in Paragraph A.1) of this Provision, and the report in Paragraph C of this Provision, for setting actuarially sound capitation rates for Contractor consistent with the requirements in 42 CFR 438.4.

- E. Contractor shall also comply with these requirements as directed in APL17-003.

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1. Payment for Services

DHCS shall pay the appropriate Capitation Payment set forth in Exhibit B, Budget Detail and Payment Provisions, Provision 4. Capitation Rates to the Contractor for each eligible Member under this Contract, and ensure that such payments are based on actuarially sound capitation rates as defined in 42 CFR 438.4 and developed in accordance with standards specified in 42 CFR 438.5. Payments will be made monthly for the duration of this Contract. Any adjustments for Federally Qualified Health Centers will be made in accordance with W & I Code 14087.325.

2. Medical Reviews

DHCS shall conduct medical reviews in accordance with W & I Code 14456. DHCS shall have the discretion to accept plan performance reports, audits or reviews conducted by other agencies or accrediting bodies that use standards comparable to those of DHCS. These plan performance reports, audits and reviews may be in lieu of an audit or review conducted by DHCS in order to eliminate duplication of auditing efforts.

3. Enrollment Processing by DHCS

A. General

The parties to this Contract agree that the primary purpose of DHCS' Medi-Cal Managed Care System is to improve quality and access to care for Medi-Cal beneficiaries. The parties acknowledge that the Medi-Cal eligibility process and the managed care enrollment system are dynamic and complex programs. The parties also acknowledge that it is impractical to ensure that every beneficiary eligible for enrollment in the Contractor's plan will be enrolled in a timely manner. Furthermore, the parties recognize that for a variety of reasons some Eligible Beneficiaries will not be enrolled in Contractor's plan and will receive Covered Services in the Medi-Cal FFS system. These reasons include, but are not limited to, the exclusion of some beneficiaries from participating in Medi-Cal managed care, the time it takes to enroll beneficiaries, and the lack of a current valid address for some beneficiaries. The parties desire to work together in a cooperative manner so that Eligible Beneficiaries who choose to or should be assigned to Contractor's plan are enrolled in Contractor's plan pursuant to the requirements of this entire Provision 3, below. The parties agree that to accomplish this goal it is necessary to be reasonably flexible with regard to the enrollment process.

B. Enrollment Processing Definitions

For purposes of this entire Provision 3. Enrollment Processing by DHCS, the following definitions shall apply:

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- 1) Fully Converted County means a county in which the following circumstances exist, except for those Medi-Cal beneficiaries covered by Title 22 CCR Section 53887:
 - a) Eligible Beneficiaries who meet the mandatory enrollment criteria contained in Title 22 CCR Section 53845(a) may no longer choose to receive Covered Services on a FFS basis; and
 - b) All new Eligible Beneficiaries who meet the mandatory enrollment criteria contained in Title 22 CCR Section 53845(a) must now choose a managed care plan or they will be assigned to a managed care plan; and
 - c) All Eligible Beneficiaries listed in the Medi-Cal Eligibility Data System (MEDS) as meeting the mandatory enrollment criteria contained in Title 22 CCR Section 53845(a) on the last date that both a. and b. above occur:
 - i. Have been notified of the requirement to choose a managed care plan and informed that if they fail to choose a plan they will be assigned to a managed care plan; and
 - ii. Those beneficiaries still eligible for Medi-Cal and enrollment into a managed care plan at the time their plan enrollment is processed in MEDS have been enrolled into a managed care plan.
- 2) Mandatory Plan Beneficiary means:
 - a) A new Eligible Beneficiary who meets the mandatory enrollment criteria contained in Title 22 CCR Section 53845(a), both at the time her/his plan enrollment is processed by the DHCS Enrollment Contractor and by MEDS; or
 - b) An Eligible Beneficiary previously receiving Covered Services in a county without mandatory managed care enrollment who now resides in a county where mandatory enrollment is in effect and who meets the mandatory enrollment criteria contained in Title 22 CCR Section 53845(a); or
 - c) An Eligible Beneficiary meeting the criteria of Title 22 CCR Section 53845(b), and who subsequently meets the criteria

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of Title 22 CCR Section 53845(a).

- 3) Mandatory Plan Beneficiary shall not include any Eligible Beneficiary who:
 - a) is eligible to receive Covered Services on a FFS basis because her/his MEDS eligibility for managed care plan enrollment is interrupted due to aid code, zip code or county code changes; or
 - b) becomes eligible for enrollment in a managed care plan on a retroactive basis.

C. DHCS Enrollment Obligations

- 1) DHCS shall receive applications for enrollment from its enrollment contractor and shall verify the current eligibility of applicants for enrollment in Contractor's plan under this Contract. If the Contractor has the capacity to accept new Members, DHCS or its enrollment contractor shall enroll or assign Eligible Beneficiaries in Contractor's plan when selected by the Eligible Beneficiary or when the Eligible Beneficiary fails to timely select a plan. Of those to be enrolled or assigned in Contractor's plan, DHCS will ensure that in a Fully Converted County a Mandatory Plan Beneficiary will receive an effective date of plan enrollment that is no later than 90 calendar days from the date that MEDS lists such an individual as meeting the enrollment criteria contained in Title 22 CCR Section 53845(a), if all changes to MEDS have been made to allow for the enrollment of the individual and all changes necessary to this Contract to accommodate such enrollment, including, but not limited to rate changes and aid code changes, have been executed. DHCS will use due diligence in making any changes to MEDS and to this Contract. DHCS will provide Contractor a list of Members on a monthly basis.
- 2) DHCS or its enrollment contractor shall assign Eligible Beneficiaries meeting the enrollment criteria contained in Title 22 CCR Section 53845(a) to plans in accordance with Title 22 CCR Section 53884.
- 3) Notwithstanding any other provision in this Contract, Sub-Paragraphs 1) and 2) above shall not apply to:
 - a) Eligible Beneficiaries previously eligible to receive Medi-Cal services from a Prepaid Health Plan or Primary Care Case Management Plan and such plan's contract with DHCS expires, terminates, or is assigned or transferred to Contractor;

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- b) Members who are enrolled into another managed care plan on account of assignment, assumption, termination, or expiration of this Contract;
- c) Eligible Beneficiaries covered by a new mandatory aid code, added to this Contract;
- d) Eligible Beneficiaries meeting the criteria of Title 22 CCR Section 53845(b), who subsequently meet the criteria of Title 22 CCR Section 53845(a) due solely to DHCS designating a prior voluntary aid code as a new mandatory aid code;
- e) Eligible Beneficiaries residing in an excluded zip code area within a county that is not a fully converted county; or
- f) Eligible Beneficiaries without a current valid deliverable address or with an address designated as a county post office box for homeless beneficiaries.

D. Disputes Concerning DHCS Enrollment Obligations

- 1) Contractor shall notify DHCS of DHCS' noncompliance with this Provision 3. Enrollment Processing pursuant to the requirements and procedures contained in Exhibit E, Attachment 2, Provision 18, Disputes.
- 2) DHCS shall have 120 calendar days from the date of DHCS' receipt of Contractor's notice (the "cure period") to cure any noncompliance with this Provision 3. Enrollment Processing, identified in Contractor's notice, without incurring any financial liability to the Contractor. For purposes of this section, DHCS shall be deemed to have cured any noncompliance with this Provision 3. Enrollment Processing, identified in Contractor's notice if within the cure period any of the following occurs:
 - a) Mandatory Plan Beneficiaries receive an effective date of plan enrollment that is within the cure period, or
 - b) DHCS corrects enrollment that failed to comply with this Provision 3. Enrollment Processing, by redirecting enrollment from one Contractor to another within the cure period in order to comply with this Provision 3. Enrollment Processing, or
 - c) Within the cure period, DHCS changes the distribution of beneficiary Assignment (subject to the requirements of Title

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22 CCR Section 53845), to the maximum extent new beneficiaries are available to be assigned, to make up the number of incorrectly assigned beneficiaries as soon as possible.

- 3) If it is necessary to redirect enrollment or change the distribution of beneficiary Assignment due to noncompliance with this Provision 3. Enrollment Processing, and such change varies from the requirements of Title 22 CCR Section 53884(b)(5) or (b)(6), Contractor agrees it will neither seek legal nor equitable relief for such variance or the results of such variance if DHCS resumes assignment consistent with Sections 53884(b)(5) or (b)(6) after correcting a noncompliance with this Provision 3, Enrollment Processing.

- 4) Notwithstanding Exhibit E, Attachment 2, Provision 1, Governing Law or any other provision of this Contract, if DHCS fails to cure a noncompliance with this Provision 3, Enrollment Processing, within the cure period, DHCS will be financially liable for such noncompliance as follows:

DHCS will be financially liable for Contractor's demonstrated actual reasonable losses as a result of the noncompliance, beginning with DHCS' first failure to comply with its enrollment obligation set forth herein. DHCS' financial liability shall not exceed 15 percent of Contractor's monthly Capitation Payment calculated as if noncompliance with this Provision 3. Enrollment Processing did not occur, for each month in which DHCS has not cured noncompliance pursuant to Paragraph D. Sub-Paragraph 2) above, beginning with DHCS' first failure to comply with its enrollment obligation set forth herein.

- 5) Notwithstanding Paragraph D. Sub-Paragraph 4) above, DHCS shall not be financially liable to Contractor for any noncompliance with Provision 3. Enrollment Processing, in an affected county (on a county-by-county basis) if Contractor's loss of Mandatory Plan Beneficiaries, in a month in which any noncompliance occurs, is less than five percent of Contractor's total Members in that affected county in the month in which the noncompliance occurs. The parties acknowledge that the above-referenced five-percent threshold shall apply on a county-by-county basis, not in the aggregate.

4. Disenrollment Processing

DHCS shall review and process requests for disenrollment and notify the Contractor and the Member of its decision.

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5. DHCS Approval Process

- A. Within five (5) working days of receipt, DHCS shall acknowledge in writing the receipt of any material sent to DHCS by Contractor pursuant to Exhibit E, Attachment 2, Provision 8, Obtaining DHCS Approval.
- B. Within 60 calendar days of receipt, DHCS shall make all reasonable efforts to approve in writing the use of such material provided to DHCS pursuant to Exhibit E, Attachment 2, Provision 8, Obtaining DHCS Approval, provide Contractor with a written explanation why its use is not approved, or provide a written estimated date of completion of DHCS' review process. If DHCS does not complete its review of submitted material within 60 calendar days of receipt, or within the estimated date of completion of DHCS review, Contractor may elect to implement or use the material at Contractor's sole risk and subject to possible subsequent disapproval by DHCS. This Paragraph shall not be construed to imply DHCS approval of any material that has not received written DHCS approval. This paragraph shall not apply to Subcontractor Agreements or Network Provider Agreements subject to DHCS approval in accordance with Exhibit A, Attachment 6, Provision 14, Network Provider Agreements and Subcontractor Agreements, Paragraph D. regarding Departmental Approval – Non-Federally Qualified HMOs, and Paragraph E. regarding Departmental Approval – Federally Qualified HMOs.

6. Program Information

DHCS shall provide Contractor with complete and current information with respect to pertinent policies, procedures, and guidelines affecting the operation of this Contract, within 30 calendar days of receipt of Contractor's written request for information, to the extent that the information is readily available. If the requested information is not available, DHCS shall notify Contractor within 30 calendar days, in writing, of the reason for the delay and when Contractor may expect the information.

7. Catastrophic Coverage Limitation

DHCS shall limit the Contractor's liability to provide or arrange and pay for care for illness of, or injury to, Members which results from or is greatly aggravated by, a catastrophic occurrence or disaster.

8. Risk Limitation

DHCS shall agree that there will be no risk limitation and that Contractor will have full financial liability to provide Medically Necessary Covered Services to Members.

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9. Notice of Termination of Contract

DHCS shall notify Members of their health care benefits and options available upon termination or expiration of this Contract.

10. Program Integrity

DHCS shall monitor during the Contract term on program integrity standards, in accordance with 42 CFR 438.602, and shall conduct the following:

- A. Monitoring of Contractor, Subcontractors, and Network Providers for compliance as applicable with 42 CFR 438.604, 438.606, 438.608, 438.610, 438.230, and 438.808.
- B. Review of the ownership and control disclosures submitted by Contractor and any Subcontractors as required in 438.608(c).
- C. Confirm the identity and determine the exclusion status of Contractor, any Subcontractor or Network Provider, as well as any person with an ownership or control interest, or who is an agent or managing employee of this Contract, through routine checks of federal databases. This includes the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/Entities (LEIE), the System for Award Management (SAM), and any other databases as the State or Secretary may prescribe. These databases must be consulted upon contracting and no less frequently than monthly thereafter. If the State finds a party that is excluded, it must promptly notify Contractor and take action consistent with 42 CFR 438.610(c).
- D. Periodically, but no less frequently than once every three (3) years, conduct, or contract for the conduct of, an independent audit of the Encounter Data and financial data submitted by, or on behalf of, Contractor.
- E. Receive and investigate information from whistleblowers relating to the integrity of Contractor, Subcontractors, or Network Providers receiving federal funds.
- F. Post on its web site as required in 42 CFR 438.602(g), the following documents and reports:
 - 1) This Contract.
 - 2) The data required in 42 CFR 438.604(a)(5).

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- 3) The name and title of individuals included in 42 CFR 438.604(a)(6).
 - 4) The results of any audits under Section E of this Provision.
- G. Implement conflict of interest safeguards described in 42 CFR 438.58 and comply with the requirements described in this Provision.
- H. Mental Health Parity
- 1) Monitor Contractor's compliance with mental health parity requirements in 42 CFR 438.900 et seq.
 - 2) Ensure that Contractor, Subcontractors, Network Providers and any contracted entities are not applying any financial or treatment limitations to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation applied to medical/surgical benefits in the same classification.

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Exhibit G
Business Associate Addendum

1. This Agreement has been determined to constitute a business associate relationship under the Health Insurance Portability and Accountability Act (HIPAA) and its implementing privacy and security regulations at 45 Code of Federal Regulations, Parts 160 and 164 (collectively, and as used in this Agreement)
2. The term “Agreement” as used in this document refers to and includes both this Business Associate Addendum and the contract to which this Business Associate Agreement is attached as an exhibit, if any.
3. For purposes of this Agreement, the term “Business Associate” shall have the same meaning as set forth in 45 CFR section 160.103.
4. The Department of Health Care Services (DHCS) intends that Business Associate may create, receive, maintain, transmit or aggregate certain information pursuant to the terms of this Agreement, some of which information may constitute Protected Health Information (PHI) and/or confidential information protected by Federal and/or state laws.
 - 4.1 As used in this Agreement and unless otherwise stated, the term “PHI” refers to and includes both “PHI” as defined at 45 CFR section 160.103 and Personal Information (PI) as defined in the Information Practices Act (IPA) at California Civil Code section 1798.3(a). PHI includes information in any form, including paper, oral, and electronic.
 - 4.2 As used in this Agreement, the term “confidential information” refers to information not otherwise defined as PHI in Section 4.1 of this Agreement, but to which state and/or federal privacy and/or security protections apply.
5. Contractor (however named elsewhere in this Agreement) is the Business Associate of DHCS acting on DHCS's behalf and provides services or arranges, performs or assists in the performance of functions or activities on behalf of DHCS, and may create, receive, maintain, transmit, aggregate, use or disclose PHI (collectively, “use or disclose PHI”) in order to fulfill Business Associate’s obligations under this Agreement. DHCS and Business Associate are each a party to this Agreement and are collectively referred to as the “parties.”
6. The terms used in this Agreement, but not otherwise defined, shall have the same meanings as those terms in HIPAA and/or IPA. Any reference to statutory or regulatory language shall be to such language as in effect or as amended.
7. **Permitted Uses and Disclosures of PHI by Business Associate.** Except as otherwise indicated in this Agreement, Business Associate may use or disclose PHI, inclusive of de-identified data derived from such PHI, only to perform

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functions, activities or services specified in this Agreement on behalf of DHCS, provided that such use or disclosure would not violate HIPAA or other applicable laws if done by DHCS.

7.1 Specific Use and Disclosure Provisions. Except as otherwise indicated in this Agreement, Business Associate may use and disclose PHI if necessary for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate. Business Associate may disclose PHI for this purpose if the disclosure is required by law, or the Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person. The person shall notify the Business Associate of any instances of which the person is aware that the confidentiality of the information has been breached, unless such person is a treatment provider not acting as a business associate of Business Associate.

8. Compliance with Other Applicable Law

8.1 To the extent that other state and/or federal laws provide additional, stricter and/or more protective (collectively, more protective) privacy and/or security protections to PHI or other confidential information covered under this Agreement beyond those provided through HIPAA, Business Associate agrees:

8.1.1 To comply with the more protective of the privacy and security standards set forth in applicable state or federal laws to the extent such standards provide a greater degree of protection and security than HIPAA or are otherwise more favorable to the individuals whose information is concerned; and

8.1.2 To treat any violation of such additional and/or more protective standards as a breach or security incident, as appropriate, pursuant to Section 18. of this Agreement.

8.2 Examples of laws that provide additional and/or stricter privacy protections to certain types of PHI and/or confidential information, as defined in Section 4. of this Agreement, include, but are not limited to the Information Practices Act, California Civil Code sections 1798-1798.78, Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, Welfare and Institutions Code section 5328, and California Health and Safety Code section 11845.5.

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8.3 If Business Associate is a Qualified Service Organization (QSO) as defined in 42 CFR section 2.11, Business Associate agrees to be bound by and comply with subdivisions (2)(i) and (2)(ii) under the definition of QSO in 42 CFR section 2.11.

9. Additional Responsibilities of Business Associate

9.1 Nondisclosure. Business Associate shall not use or disclose PHI or other confidential information other than as permitted or required by this Agreement or as required by law.

9.2 Safeguards and Security.

9.2.1 Business Associate shall use safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI and other confidential data and comply, where applicable, with subpart C of 45 CFR Part 164 with respect to electronic protected health information, to prevent use or disclosure of the information other than as provided for by this Agreement. Such safeguards shall be based on applicable Federal Information Processing Standards (FIPS) Publication 199 protection levels.

9.2.2 Business Associate shall, at a minimum, utilize a National Institute of Standards and Technology Special Publication (NIST SP) 800-53 compliant security framework when selecting and implementing its security controls and shall maintain continuous compliance with NIST SP 800-53 as it may be updated from time to time. The current version of NIST SP 800-53, Revision 5, is available online at <https://csrc.nist.gov/publications/detail/sp/800-53/rev-5/final>; updates will be available online at <https://csrc.nist.gov/publications/sp800>.

9.2.3 Business Associate shall employ FIPS 140-2 validated encryption of PHI at rest and in motion unless Business Associate determines it is not reasonable and appropriate to do so based upon a risk assessment, and equivalent alternative measures are in place and documented as such. FIPS 140-2 validation can be determined online at <https://csrc.nist.gov/projects/cryptographic-module-validation-program/validated-modules/search>, with information about the Cryptographic Module Validation Program under FIPS 140-2 available online at <https://csrc.nist.gov/Projects/cryptographic-module-validation-program/fips-140-2>. In addition, Business Associate shall

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maintain, at a minimum, the most current industry standards for transmission and storage of PHI and other confidential information.

9.2.4 Business Associate shall apply security patches and upgrades, and keep virus software up-to-date, on all systems on which PHI and other confidential information may be used.

9.2.5 Business Associate shall ensure that all members of its workforce with access to PHI and/or other confidential information sign a confidentiality statement prior to access to such data. The statement must be renewed annually.

9.2.6 Business Associate shall identify the security official who is responsible for the development and implementation of the policies and procedures required by 45 CFR Part 164, Subpart C.

9.3 Business Associate's Agent. Business Associate shall ensure that any agents, subcontractors, subawardees, vendors or others (collectively, "agents") that use or disclose PHI and/or confidential information on behalf of Business Associate agree to the same restrictions and conditions that apply to Business Associate with respect to such PHI and/or confidential information.

- 10. Mitigation of Harmful Effects.** Business Associate shall mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI and other confidential information in violation of the requirements of this Agreement.
- 11. Access to PHI.** Business Associate shall make PHI available in accordance with 45 CFR section 164.524.
- 12. Amendment of PHI.** Business Associate shall make PHI available for amendment and incorporate any amendments to protected health information in accordance with 45 CFR section 164.526.
- 13. Accounting for Disclosures.** Business Associate shall make available the information required to provide an accounting of disclosures in accordance with 45 CFR section 164.528.
- 14. Compliance with DHCS Obligations.** To the extent Business Associate is to carry out an obligation of DHCS under 45 CFR Part 164, Subpart E, comply with the requirements of the subpart that apply to DHCS in the performance of such obligation.

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- 15. Access to Practices, Books and Records.** Business Associate shall make its internal practices, books, and records relating to the use and disclosure of PHI on behalf of DHCS available to DHCS upon reasonable request, and to the federal Secretary of Health and Human Services for purposes of determining DHCS' compliance with 45 CFR Part 164, Subpart E.
- 16. Return or Destroy PHI on Termination; Survival.** At termination of this Agreement, if feasible, Business Associate shall return or destroy all PHI and other confidential information received from, or created or received by Business Associate on behalf of, DHCS that Business Associate still maintains in any form and retain no copies of such information. If return or destruction is not feasible, Business Associate shall notify DHCS of the conditions that make the return or destruction infeasible, and DHCS and Business Associate shall determine the terms and conditions under which Business Associate may retain the PHI. If such return or destruction is not feasible, Business Associate shall extend the protections of this Agreement to the information and limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
- 17. Special Provision for SSA Data.** If Business Associate receives data from or on behalf of DHCS that was verified by or provided by the Social Security Administration (SSA data) and is subject to an agreement between DHCS and SSA, Business Associate shall provide, upon request by DHCS, a list of all employees and agents and employees who have access to such data, including employees and agents of its agents, to DHCS.
- 18. Breaches and Security Incidents.** Business Associate shall implement reasonable systems for the discovery and prompt reporting of any breach or security incident, and take the following steps:

 - 18.1 Notice to DHCS.**

 - 18.1.1** Business Associate shall notify DHCS immediately upon the discovery of a suspected breach or security incident that involves SSA data. This notification will be provided by email upon discovery of the breach. If Business Associate is unable to provide notification by email, then Business Associate shall provide notice by telephone to DHCS.
 - 18.1.2** Business Associate shall notify DHCS within 24 hours by email (or by telephone if Business Associate is unable to email DHCS) of the discovery of the following, unless attributable to a treatment provider that is not acting as a business associate of Business Associate:

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- 18.1.2.1** Unsecured PHI if the PHI is reasonably believed to have been accessed or acquired by an unauthorized person;
- 18.1.2.2** Any suspected security incident which risks unauthorized access to PHI and/or other confidential information;
- 18.1.2.3** Any intrusion or unauthorized access, use or disclosure of PHI in violation of this Agreement; or
- 18.1.2.4** Potential loss of confidential information affecting this Agreement.

18.1.3 Notice shall be provided to the DHCS Program Contract Manager (as applicable), the DHCS Privacy Office, and the DHCS Information Security Office (collectively, "DHCS Contacts") using the DHCS Contact Information at Section 18.6. below.

Notice shall be made using the current DHCS "Privacy Incident Reporting Form" ("PIR Form"; the initial notice of a security incident or breach that is submitted is referred to as an "Initial PIR Form") and shall include all information known at the time the incident is reported. The form is available online at <https://www.dhcs.ca.gov/formsandpubs/laws/priv/Documents/Privacy-Incident-Report-PIR.pdf>.

Upon discovery of a breach or suspected security incident, intrusion or unauthorized access, use or disclosure of PHI, Business Associate shall take:

- 18.1.3.1** Prompt action to mitigate any risks or damages involved with the security incident or breach; and
- 18.1.3.2** Any action pertaining to such unauthorized disclosure required by applicable Federal and State law.

18.2 Investigation. Business Associate shall immediately investigate such security incident or breach.

18.3 Complete Report. To provide a complete report of the investigation to the DHCS contacts within ten (10) working days of the discovery of the security incident or breach. This "Final PIR" must include any applicable

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additional information not included in the Initial Form. The Final PIR Form shall include an assessment of all known factors relevant to a determination of whether a breach occurred under HIPAA and other applicable federal and state laws. The report shall also include a full, detailed corrective action plan, including its implementation date and information on mitigation measures taken to halt and/or contain the improper use or disclosure. If DHCS requests information in addition to that requested through the PIR form, Business Associate shall make reasonable efforts to provide DHCS with such information. A “Supplemental PIR” may be used to submit revised or additional information after the Final PIR is submitted. DHCS will review and approve or disapprove Business Associate’s determination of whether a breach occurred, whether the security incident or breach is reportable to the appropriate entities, if individual notifications are required, and Business Associate’s corrective action plan.

18.3.1 If Business Associate does not complete a Final PIR within the ten (10) working day timeframe, Business Associate shall request approval from DHCS within the ten (10) working day timeframe of a new submission timeframe for the Final PIR.

18.4 Notification of Individuals. If the cause of a breach is attributable to Business Associate or its agents, other than when attributable to a treatment provider that is not acting as a business associate of Business Associate, Business Associate shall notify individuals accordingly and shall pay all costs of such notifications, as well as all costs associated with the breach. The notifications shall comply with applicable federal and state law. DHCS shall approve the time, manner and content of any such notifications and their review and approval must be obtained before the notifications are made.

18.5 Responsibility for Reporting of Breaches to Entities Other than DHCS. If the cause of a breach of PHI is attributable to Business Associate or its agents, other than when attributable to a treatment provider that is not acting as a business associate of Business Associate, Business Associate is responsible for all required reporting of the breach as required by applicable federal and state law.

18.6 DHCS Contact Information. To direct communications to the above referenced DHCS staff, the Contractor shall initiate contact as indicated here. DHCS reserves the right to make changes to the contact information below by giving written notice to Business Associate. These changes shall not require an amendment to this Agreement.

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DHCS Program Contract Manager	DHCS Privacy Office	DHCS Information Security Office
See the Scope of Work exhibit for Program Contract Manager information. If this Business Associate Agreement is not attached as an exhibit to a contract, contact the DHCS signatory to this Agreement.	Privacy Office c/o: Office of HIPAA Compliance Department of Health Care Services P.O. Box 997413, MS 4722 Sacramento, CA 95899-7413 Email: incidents@dhcs.ca.gov Telephone: (916) 445-4646	Information Security Office DHCS Information Security Office P.O. Box 997413, MS 6400 Sacramento, CA 95899-7413 Email: incidents@dhcs.ca.gov

19. Responsibility of DHCS. DHCS agrees to not request the Business Associate to use or disclose PHI in any manner that would not be permissible under HIPAA and/or other applicable federal and/or state law.

20. Audits, Inspection and Enforcement

20.1 From time to time, DHCS may inspect the facilities, systems, books and records of Business Associate to monitor compliance with this Agreement. Business Associate shall promptly remedy any violation of this Agreement and shall certify the same to the DHCS Privacy Officer in writing. Whether or how DHCS exercises this provision shall not in any respect relieve Business Associate of its responsibility to comply with this Agreement.

20.2 If Business Associate is the subject of an audit, compliance review, investigation or any proceeding that is related to the performance of its obligations pursuant to this Agreement, or is the subject of any judicial or administrative proceeding alleging a violation of HIPAA, Business Associate shall promptly notify DHCS unless it is legally prohibited from doing so.

21. Termination

21.1 Termination for Cause. Upon DHCS' knowledge of a violation of this Agreement by Business Associate, DHCS may in its discretion:

21.1.1 Provide an opportunity for Business Associate to cure the violation and terminate this Agreement if Business Associate does not do so within the time specified by DHCS; or

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21.1.2 Terminate this Agreement if Business Associate has violated a material term of this Agreement.

21.2 Judicial or Administrative Proceedings. DHCS may terminate this Agreement if Business Associate is found to have violated HIPAA, or stipulates or consents to any such conclusion, in any judicial or administrative proceeding.

22. Miscellaneous Provisions

22.1 Disclaimer. DHCS makes no warranty or representation that compliance by Business Associate with this Agreement will satisfy Business Associate's business needs or compliance obligations. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI and other confidential information.

22.2. Amendment.

22.2.1 Any provision of this Agreement which is in conflict with current or future applicable Federal or State laws is hereby amended to conform to the provisions of those laws. Such amendment of this Agreement shall be effective on the effective date of the laws necessitating it, and shall be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

22.2.2 Failure by Business Associate to take necessary actions required by amendments to this Agreement under Section 22.2.1 shall constitute a material violation of this Agreement.

22.3 Assistance in Litigation or Administrative Proceedings. Business Associate shall make itself and its employees and agents available to DHCS at no cost to DHCS to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against DHCS, its directors, officers and/or employees based upon claimed violation of HIPAA, which involve inactions or actions by the Business Associate.

22.4 No Third-Party Beneficiaries. Nothing in this Agreement is intended to or shall confer, upon any third person any rights or remedies whatsoever.

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Business Associate Addendum

- 22.5 Interpretation.** The terms and conditions in this Agreement shall be interpreted as broadly as necessary to implement and comply with HIPAA and other applicable laws.
- 22.6 No Waiver of Obligations.** No change, waiver or discharge of any liability or obligation hereunder on any one or more occasions shall be deemed a waiver of performance of any continuing or other obligation, or shall prohibit enforcement of any obligation, on any other occasion.