

Exhibit A SCOPE OF WORK

1. Service Overview

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

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

2. Service Location

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

3. Project Representatives

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

Department of Health Care Services	Contractor
Managed Care Operations Division Attn: Chief, Managed Care Systems & Support Branch	Address
Telephone: (916) 449-5000 Fax: (916) 449-5090	Telephone: Fax:

B. Direct all inquiries to:

Department of Health Care Services	Contractor
Managed Care Operations Division County Organized Health Systems Attn: Contracting Officer	Address
MS 4408 P.O. Box 997413 Sacramento, CA 95899-7413	
Telephone: (916) 449-5000 Fax: (916) 449-5090	Telephone: Fax:

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

**Exhibit A
SCOPE OF WORK**

this Contract.

- 4.** See the following attached exhibits labeled Exhibit A, Attachment 1 through 25 for a detailed description of the services to be performed.

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

1. Legal Capacity

Contractor shall maintain the legal capacity to contract with DHCS.

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 a five (5) percent 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. Contractor shall comply with Federal regulations 42 CFR 455.104 (Disclosure by providers and fiscal agents: Information on ownership and control), 42 CFR 455.105 (Disclosure by providers: Information related to business transactions), 42 CFR 455.106.

3. Conflict of Interest – Current And Former State Employees

- A. This Contract shall be governed by the Conflict of Interest provisions of Title 22 California Code of Regulations (CCR) Section 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. Contractor shall not utilize in the performance of this Contract any former State officer or employee or other appointed official in violation of the provisions of Government Code Section 87406. For purposes of this subparagraph B only, employee in the State civil service is defined to be any person legally holding a permanent or intermittent position in the State civil service.

4. Contract Performance

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

Contractor shall maintain the organization and staffing for implementing and operating the Contract in accordance with Title 28 CCR Section 1300.67.3. Contractor shall ensure the following:

- A. The organization has an accountable governing body.
- B. This Contract is a high priority and that the Contractor is committed to supplying any necessary resources to assure full performance of the Contract.
- C. Contractor shall attest to the compliance and successful fulfillment of the terms, conditions, provisions and responsibilities set forth in this Contract. Contractor shall also attest to providing any and all necessary resources to assure full performance of the Contract.
- D. Staffing in medical and other health services, and in fiscal and administrative services sufficient to result in the effective conduct of the Contractor's business.
- E. Written procedures for the conduct of the business of the Contractor, including the provision of health care services, so as to provide effective controls.

5. Medical Decisions

Contractor shall ensure that medical decisions, including those by Sub-contractors and rendering Providers, are not unduly influenced by fiscal and administrative management.

6. Medical Director

Contractor shall maintain a full time Physician as Medical Director 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 unduly influenced by fiscal or administrative management considerations.
- B. Ensuring that the medical care provided meets the standards for acceptable medical care.

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

- C. Ensuring that medical protocols and Standards of Conduct for plan medical personnel are followed.
- D. Developing and implementing medical policy.
- E. Resolve Grievances related to medical quality of care. For purposes of this provision, the resolution of grievances related to medical quality of care may be by the Medical Director's physician designee.
- F. Have a role in the implementation of Quality Improvement activities.
- G. Actively participate in the functioning of the Grievance and Appeal procedures as specified in Exhibit A, Attachment 14, Member Grievance and Appeal System.

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

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

- E. Claims processing capabilities as described in Exhibit A, Attachment 8, Provider Compensation Arrangements.
- F. Contractor shall implement and maintain a system for providing Members health education services, clinical preventive services and patient education consistent with Exhibit A, Attachment 10. Provision 8. Services for All Members.
- G. Contractor shall operate a provider Grievance procedure.
- H. Contractor shall implement and maintain a Quality Improvement System consistent with Exhibit A, Attachment 4, Quality Improvement System.

9. Member Representation

Contractor shall ensure that Medi-Cal Members, including Seniors and Persons with Disabilities (SPD) or persons with chronic conditions (such as asthma, diabetes, congestive heart failure), 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 guidelines as established under Title 28 CCR Section 1300.78.

C. Standards of Organization and Financial Soundness.

Contractor shall maintain an organizational structure sufficient to conduct the proposed operations and ensure that its financial resources are sufficient for sound business operations in accordance with 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 Health and Safety Code, Section 1375.1.

D. Working capital and current ratio of one (1) of the following:

- 1) Contractor shall maintain a working capital ratio of at least 1:1; or
- 2) Contractor shall demonstrate to DHCS that Contractor is meeting financial obligations on a timely basis and has been doing so for at least the preceding 24 months; or
- 3) Contractor shall provide evidence that sufficient noncurrent assets, which are readily convertible to cash, are available to achieve an equivalent working capital ratio of 1:1, if the noncurrent assets are considered current.

2. Financial Audit Reports

Contractor shall ensure that an annual audit is performed according to Welfare and Institutions Code Section 14459. 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

**Exhibit A, Attachment 2
FINANCIAL INFORMATION**

transactions and profits shall be eliminated if combined statements are prepared. If an independent accountant decides that preparation of combined statements is inappropriate, Contractor shall have separate certified Financial Statements prepared for each entity.

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

**Exhibit A, Attachment 2
FINANCIAL INFORMATION**

- h) Schedule H: Aging Of All Claims.
- C. Contractor shall authorize its independent accountant to allow DHCS designated representatives or agents, upon written request, to inspect any and all working papers related to the preparation of the audit report.
- D. Contractor shall submit to DHCS all financial reports relevant to Affiliates.
- E. Contractor shall submit to DHCS copies of any financial reports submitted to other public or private organizations if such reports differ in content from any financial report already submitted to DHCS.
- F. Contractor shall submit to DHCS, within 45 calendar days after the close of the Contractor's fiscal quarter, a Statement of Revenues, Expenses, and Net Worth including only Medi-Cal revenues and expenses using the reporting forms required by DMHC.
- G. Contractor shall submit to DHCS, no later than June 30th of each contract year, projected Revenues, Expenses and Net Worth for each quarter of the following State Fiscal Year. The submission must include a detailed explanation of the assumptions used to develop the financial forecasts.

3. 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.

**Exhibit A, Attachment 2
FINANCIAL INFORMATION**

- 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 the DMHC, Contractor and/or Subcontractor shall simultaneously file monthly Financial Statements with DHCS. Even if not required to file monthly Financial Statements by DMHC, Contractor may be required to file monthly Financial Statements at DHCS' request.

5. Compliance with Audit Requirements

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

6. Submittal of Financial Information

Contractor shall prepare financial information requested in accordance with GAAP. Where Financial Statements and projections are requested, these statements and projections should be prepared in accordance with the 1989 HMO Financial Report of Affairs and Conditions Format. Where appropriate, reference has been made to the Knox-Keene Health Care Service Plan Act of 1975 rules found 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.

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

7. Fiscal Viability of Subcontracting Entities

Contractor shall maintain a system to evaluate and monitor the financial viability of all subcontracting risk-bearing organizations; as such organizations are defined in Health and Safety Code Section 1375.4(g).

**Exhibit A, Attachment 3
MANAGEMENT INFORMATION SYSTEM**

1. Management Information System (MIS) Capability

- A. Contractor shall implement and maintain an MIS system that can process and provide all Medi-Cal eligibility, membership enrolled with Contractor, provider claims payment and status. Encounter-level health care services delivery, provider network, financial, and any other data necessary to carry out all processes and procedures needed by Contractor to perform and administer all of the functions required under this Contract. All data shall be available to DHCS and to the Centers for Medicare and Medicaid Services (CMS) upon request. Request for data shall be in writing and specify the timeframe, format, and method required for submission.
- B. Contractor shall implement policies and procedures for ensuring the complete, accurate, and timely submission of data for all services for which Contractor incurred any financial liability whether directly or through Subcontracts or other arrangements. The MIS shall be able to collect, process, edit, and submit:
 - 1) Utilization and Statistical Data
 - a) Utilization of services or encounters by and benefits to Members;
 - b) Cost of health care;
 - c) Administrative expenses;
 - d) Quality of care rendered compliant with Exhibit A, Attachment 4, Quality Improvement System; and
 - e) Other utilization Encounter and financial information required for auditing purposes or calculations of capitation rates.

2. Encounter Data Reporting

- A. Contractor shall maintain a MIS that collects and reports Encounter Data to DHCS in compliance with 42 CFR 438.242, and pursuant to applicable DHCS All Plan Letters (APL).
- B. Contractor shall implement policies and procedures for ensuring submission of complete, accurate, reasonable, and timely Encounter Data to DHCS for all items and services furnished to a Member under this Contract, whether directly or through Subcontracts or other arrangements, including capitated Providers. Encounter Data shall be submitted on at

**Exhibit A, Attachment 3
MANAGEMENT INFORMATION SYSTEM**

least a monthly basis in a form and manner specified by DHCS.

- C. Contractor shall require Subcontractors and non-contracting 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, timely, reasonable, and accurate prior to submission to DHCS. Contractor shall ensure the completeness, accuracy, reasonability, and timeliness of all Subcontractor Encounter Data regardless of whether Subcontractor is reimbursed on a Fee-For-Service (FFS) or capitated basis.
- D. Contractor shall submit complete, accurate, reasonable, and timely Encounter Data to DHCS 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 form and manner specified in DHCS.
- E. DHCS shall review and validate the Encounter Data for completeness, accuracy, reasonability, and timeliness.
- F. If DHCS finds any deficiencies regarding the completeness, accuracy, reasonability, 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 and 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 438.602(e).

3. MIS/Data Correspondence

Upon written notice by DHCS of any problems related to the submittal of data to DHCS as required under this Contract, or upon written notice by DHCS of

**Exhibit A, Attachment 3
MANAGEMENT INFORMATION SYSTEM**

concerns regarding any other changes or clarifications made by Contractor to its MIS system, Contractor shall submit Corrective Actions with measurable benchmarks within five (5) working days from the date of the postmark of DHCS' written notice to Contractor. Within 30 days of DHCS' receipt of Contractor's Corrective Action plan, DHCS shall approve the Corrective Action plan or request revisions. Within 15 days after receipt of a request for revisions to the Corrective Action plan, Contractor shall submit a revised Corrective Action plan for DHCS approval. Contractor shall submit to DHCS any proposed material changes or modifications to the MIS system for approval by DHCS 60 working days prior to changes/modifications being implemented. Within 30 days of DHCS' receipt of Contractor's modifications or proposed changes, DHCS shall acknowledge the modifications or change requests.

4. Timely, Complete and Accurate Data Submission

Contractor shall ensure that the Paid Claims and Encounter data submitted to DHCS are timely, complete and accurate and in compliance with the requirements of DHCS' most recent Medi-Cal 35-file Paid Claims Data Dictionary and if applicable the Encounter Data Element Dictionary for Managed Care Plans. Upon written notice by DHCS that Paid Claims and Encounter data is insufficient or inaccurate, Contractor shall ensure that corrected data is submitted within 15 calendar days.

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

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

6. Participation in the State Pharmacy 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 in Section 1927(k)(2) of the Social Security Act.

- 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 claim, including eligible Physician Administered Drug claims.

**Exhibit A, Attachment 3
MANAGEMENT INFORMATION SYSTEM**

- 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 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 Providers rendering services on its behalf, in any setting. Contractor shall be accountable for the quality of all Covered Services regardless of the number of contracting and subcontracting layers between Contractor and the Provider. This provision does not create a cause of action against the Contractor on behalf of a Medi-Cal beneficiary for malpractice committed by a Subcontractor.

2. Accountability

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

3. Governing Body

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

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

4. Quality Improvement Committee

Contractor shall implement and maintain a Quality Improvement Committee (QIC) designated by, and accountable to, the governing body; the Medical Director or a physician designee shall actively participate on the committee.

Exhibit A, Attachment 4
QUALITY IMPROVEMENT SYSTEM

Contractor must ensure that Subcontractors, who are representative of the composition of the Provider Network including but not limited to Subcontractors who provide health care services to Seniors and Persons with Disabilities or chronic conditions (such as asthma, diabetes, congestive heart failure), actively participate on the committee or medical sub-committee that reports to QIC.

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

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

5. Provider Participation

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

6. Delegation of Quality Improvement Activities

- A. Contractor is accountable for all quality improvement functions and responsibilities (e.g. Utilization Management, Credentialing and Site Review) that are delegated to Subcontractors. If Contractor delegates quality improvement functions, Contractor and delegated entity (Subcontractor) shall include in their Subcontract, at 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.

Exhibit A, Attachment 4
QUALITY IMPROVEMENT SYSTEM

- B. Contractor shall maintain a system to ensure accountability for delegated Quality Improvement activities, that at a minimum:
- 1) Evaluates Subcontractor's ability to perform the delegated activities including an initial review to assure that the Subcontractor has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities.
 - 2) Ensures Subcontractor meets standards set forth by the Contractor and DHCS.
 - 3) Includes the continuous monitoring, evaluation and approval of the delegated functions.

7. Written Description

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

- A. Organizational commitment to the delivery of quality health care services as evidenced by goals and objectives which are approved by Contractor's governing body and periodically evaluated and updated.
- B. Organizational chart showing the key staff and the committees and bodies responsible for Quality Improvement activities including reporting relationships of QIS committee(s) and staff within Contractor's organization.
- C. Qualifications of staff responsible for quality improvement studies and activities, including education, experience and training.
- D. A description of the system for Provider review of QIS findings, which at a minimum, demonstrates physician and other appropriate professional involvement and includes provisions for providing feedback to staff and Providers, regarding QIS study outcomes.
- E. The role, structure, and function of the quality improvement committee.
- F. The processes and procedures designed to ensure that all Medically Necessary Covered Services are available and accessible to all Members regardless of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other

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

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.
- 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 provided 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;

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

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 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 42, USC, Section 1396u-2(c)(2), and 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.

A. External Accountability Set (EAS) Performance Measures

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

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

The EAS performance measures consists of a set of Healthcare Effectiveness Data Information Set (HEDIS®) measures developed by the National Committee for Quality Assurance (NCQA). The EAS performance measures may also include other standardized

Exhibit A, Attachment 4
QUALITY IMPROVEMENT SYSTEM

performance measures and/or DHCS developed performance measures selected by DHCS for evaluation of health plan performance.

- 2) Contractor shall calculate and report all EAS performance measures at the county level unless otherwise approved by DHCS.
 - a) HEDIS rates are to be calculated by the Contractor and verified by the DHCS-selected EQRO. Rates for DHCS-developed performance measures will be calculated by the EQRO.
 - b) Contractor shall report audited results on the EAS performance measures to DHCS no later than June 15 of each year or such date as established by DHCS. Contractor shall initiate reporting on EAS performance measures for the reporting cycle following the first year of operation.
- 3) Contractor shall meet or exceed the DHCS established Minimum Performance Level (MPL) for each HEDIS measure, and any other EAS performance measures required pursuant to this Provision.
 - a) For each measure that does not meet the MPL set for that year, or is reported as a "Not Report" (NR) due to an audit failure, Contractor must submit a plan outlining the steps that will be taken to improve the subsequent year's performance.
 - b) The improvement plan must include, at a minimum, identification of the team that will address the problem, a root cause analysis, identification of interventions that will be implemented, and a proposed timeline.
 - c) Improvement plans are due to DHCS within 60 calendar days of DHCS' notification that the Contractor has performed at or below the MPL for the period under review.
 - d) Additional reporting may be required of the Contractor until such time as improvement is demonstrated.

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 or any other

Exhibit A, Attachment 4
QUALITY IMPROVEMENT SYSTEM

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 two (2) PIPs per year, approved by DHCS. If Contractor holds multiple managed care contracts with DHCS, Contractor is required to conduct or participate in two (2) PIPs for each contract. At its sole discretion, DHCS may require Contractor to conduct or participate in additional PIPs.
 - a) One PIP must be either an internal performance improvement project (IPIP) or a small group collaborative (SGC) facilitated by a health plan or DHCS. The SGC must include a minimum of two (2) DHCS health plan contractors and must use standardized measures and clinical practice guidelines. Additionally, all contracting health plans participating in a SGC must agree to the same goal, timelines for development, implementation, and measurement. Contracting health plans participating in a SGC must also agree on the nature of contracting health plan commitment of staff and other resources to the collaborative project.
 - b) One PIP must be a DHCS facilitated Statewide Collaborative. If this Contract's operation start date is after the Statewide Collaborative has begun implementation, upon DHCS' approval, Contractor may substitute a SGC and/or IPIP in place of the Statewide Collaborative.
- 2) If this Contract covers multiple counties, Contractor must include all counties in a PIP unless otherwise approved by DHCS.
- 3) Contractor shall comply with APL 16-018 and shall use the PIP reporting format designated therein to request approval of proposed PIPs from DHCS and to report at least annually to DHCS on the

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

status of each PIP. The required documentation for PIP proposals and for PIP status reports shall include but is not limited to:

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

D. Consumer Satisfaction Survey

At intervals as determined by DHCS, DHCS' contracted EQRO will conduct a consumer satisfaction survey. Contractor shall provide appropriate data to the EQRO to facilitate this survey.

10. Site Review

A. General Requirement

Contractor shall conduct Facility site and Medical Record reviews on all Primary Care Provider sites in accordance with the Site Review Policy Letter, Policy Letter (PL) 14-004 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 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 five (5) percent 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.

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

C. Credentialing Site Review

A site review is required as part of the credentialing process when both the facility and the Provider are added to the Contractor's Provider Network. If a Provider is added to Contractor's Provider Network, and the Provider site has a current passing site review survey score, a site survey need not be repeated for Provider credentialing or 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 PL 14-004, the Site Review Policy Letter. Primary Care Provider sites that do not correct cited deficiencies are to be terminated from Contractor's Network according to guidelines set forth in PL 14-004.

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 in MMCD Policy Letter 02-02 shall be included in the data submission report.

F. Continuing Oversight

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

11. Disease Surveillance

Contractor shall implement and maintain policies and procedures that set forth how diseases or conditions that must be reported to public health authorities as required by State law shall be reported. Policies and procedures shall include, for each reporting requirement, whether reporting shall be performed by Contractor or by Contractor's providers, or both.

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 16-012, and including but not limited

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

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 20, 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 including physicians and Specialists, 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 have a valid National Provider Identifier (NPI) number. Providers that have been terminated from either Medicare or Medicaid/Medi-Cal cannot participate in Contractor's Provider Network.

B. CLIA Certification

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.

C. 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.

D. Credentialing Provider Organization Certification

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

E. Disciplinary Actions

Contractor shall implement and maintain a system for the reporting of

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

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.

F. Medi-Cal and Medicare Provider Status

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

G. Health Plan Accreditation

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

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

H. Credentialing of Other Non-Physician Medical Practitioners

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

13. Medical Records

A. General Requirement

Contractor shall ensure that appropriate Medical Records for Members, pursuant to Title 28 CCR Section 1300.80(b)(4) Title 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

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

Section 53861, and PL 14-004 as required and approved by CMS.

B. Medical Records

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

- 1) Initial Health Assessment within 120 days of enrollment.
- 2) For storage and filing of medical records including: collection, processing, maintenance, storage, retrieval identification, and distribution.
- 3) To ensure that medical records are protected and confidential in accordance with all Federal and State laws.
- 4) For the release of information and obtaining consent for treatment.
- 5) To ensure maintenance of medical records in a legible, current, detailed, organized and comprehensive manner (records may be electronic or paper copy).

C. On-Site Medical Record

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

D. Member Medical Record

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

- 1) Member identification on each page; personal/biographical data in the record.
- 2) Initial Health Assessment within 120 days of enrollment in accordance with PL 08-003.
- 3) Member's preferred language (if other than English) prominently noted in the record, as well as the request or refusal of language/interpretation services.
- 4) All entries dated and author identified; for member visits, the entries

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

shall include at a minimum, the subjective complaints, the objective findings, and the diagnosis and treatment plan.

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

**Exhibit A, Attachment 5
UTILIZATION MANAGEMENT**

1. Utilization Management (UM) Program

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

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

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

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

**Exhibit A, Attachment 5
UTILIZATION MANAGEMENT**

- H. Procedures for continuously reviewing the performance of health care personnel, the utilization of services and facilities, and cost.
- I. 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 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.
- J. 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 any contracted entity, 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 contracting health care 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 contracting health care 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.

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

**Exhibit A, Attachment 5
UTILIZATION MANAGEMENT**

appropriate.

- B. Qualified health care professionals supervise review decisions, including service reductions, and a qualified Physician will review all denials that are made, whole or in part, on the basis of Medical Necessity. For purposes of this provision, a qualified Physician or Contractor's Pharmacist may approve, defer, modify, or deny Prior 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.
- C. There is a set of written criteria or guidelines for Utilization Review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated.
- D. Reasons for decisions are clearly documented.
- E. 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 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 conditions and may use other resources to make decisions.
- 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 Members
- G. Decisions and Appeals are made in a timely manner and are not unduly delayed for medical conditions requiring time sensitive services.
- H. Prior Authorization requirements shall not be applied to Emergency Services, Minor Consent 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 20. B. Records Retention.

**Exhibit A, Attachment 5
UTILIZATION MANAGEMENT**

- 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: Upon receipt of an authorization request from an emergency services provider, Contractor shall render a decision within 30 minutes or the request is deemed approved, pursuant to Title 28 CCR Section 1300.71.4.
- C. Non-urgent care following an exam in the emergency room: Response to request within 30 minutes or deemed approved.
- D. Concurrent review of authorization for treatment regimen already in place: Within 24 hours of the decision, consistent with urgency of the Member's medical condition and in accordance with Health and Safety Code Section 1367.01 (h)(3).
- E. Retrospective review: Within 30 calendar days in accordance with Health and Safety Code Section 1367.01(h)(1)
- F. Pharmaceuticals: For all covered outpatient drug Prior Authorization requests, provide notice by telephone, fax, email or other electronic communication within 24 hours of receipt of the request, and in emergency situations dispense at least a 72-hour supply of the covered outpatient drug, in accordance with Welfare and Institutions Code Section 14185(a)(1), 42 CFR 438.3(s)(6), and Section 1927(d)(5)(A) of the Social Security Act or any respective future amendments thereto.
- G. 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/supplies necessary for delivery of these special foods are set

**Exhibit A, Attachment 5
UTILIZATION MANAGEMENT**

forth in PL 14-003, Welfare and Institutions Code Section 14103.6 and Health and Safety Code Section 1367.01.

- H. 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(h)(1), or any future amendments thereto, but, no longer than 14 calendar days from the receipt of the request. The decision may be deferred and the time limit extended an additional 14 calendar days only where the Member or the Member's Provider requests an extension, or the Contractor can provide justification upon request by the State for the need for additional information and how it is in the Member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.
- I. Expedited authorizations: For requests in which a Provider indicates, or Contractor or a Subcontractor 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, the Contractor must make an expedited authorization decision and provide notice as expeditiously as the Member's health condition requires and no later than 72 hours after receipt of the request for services. The Contractor may extend the 72 hours' time period by up to 14 calendar days if the Member requests an extension, or if the 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.

4. Review of Utilization Data

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

5. Delegating UM Activities

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

**Exhibit A, Attachment 6
PROVIDER NETWORK****1. Network Capacity**

Contractor shall submit a complete Provider Network that is adequate to provide required Covered Services for Eligible Beneficiaries, including SPD beneficiaries, within Contractor's Service Area. Contractor will increase the capacity of the Network as necessary to accommodate growth.

Within each Service Area, Contractor shall ensure and monitor an appropriate Network, including adult and pediatric PCPs, OB/GYN, adult and pediatric behavioral health Providers, adult and pediatric Specialists, professional, Allied Health Care Personnel, supportive paramedical personnel, hospitals, and pharmacies 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.

2. 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.

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

**Exhibit A, Attachment 6
PROVIDER NETWORK**

4. Emergency Services

Contractor shall have, as a minimum, a designated emergency service facility within the Service Area, providing care on a 24 hours a day, 7 days a week basis. This designated emergency service facility will have one or more Physicians and one (1) Nurse on duty in the facility at all times.

5. Specialists

Contractor shall provide accessibility to medically required Specialists who are certified or eligible for certification by the appropriate specialty board, through contracting or referral. Contractor shall maintain adequate numbers and types of Specialists within their Network to accommodate the need for specialty care in accordance with W & I Code section 14182(c)(2).

6. 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 1396b(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 6.

7. Time and Distance Standard

Contractor shall maintain a Network of PCPs that are located within 30 minutes or 10 miles of a Member's residence unless Contractor has a DHCS-approved alternative time and distance standard.

8. Plan Physician Availability

Contractor shall have a plan health professional or a contracting Physician available 24-hours a day, 7-days a 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.

9. Network Provider Availability

**Exhibit A, Attachment 6
PROVIDER NETWORK**

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

10. Provider Network Report

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 to the Network affecting Provider capacity and services, including:
 - a. Change in services or benefits.
 - b. Geographic access for the Members.
 - c. Cultural and linguistic services to the extent possible.
 - d. The percentage of Traditional and Safety-Net Providers.
 - e. The number of Members assigned to each Primary Care Physician.
 - f. The percentage of Members assigned to Traditional and Safety-Net Providers.
 - g. The Network Providers who are not accepting new patients.
 - h. Provider and Provider staff language capability.

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

11. Plan Subcontractors

Contractor shall submit to DHCS, a quarterly report containing the names of all direct subcontracting provider groups including health maintenance organizations, independent physician associations, medical groups, and FQHCs and their subcontracting health maintenance organizations, independent

**Exhibit A, Attachment 6
PROVIDER NETWORK**

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 Subcontractor. The report shall be submitted within 30 calendar days following the end of the reporting quarter.

12. Ethnic and Cultural Composition

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

13. Subcontracts

Contractor may enter into Subcontracts with other entities in order to fulfill the obligations of the Contract. Contractor shall maintain policies and procedures, approved by DHCS, to ensure that Subcontractors fully comply with all terms and conditions of this Contract. When doing so, Contractor shall evaluate the prospective Subcontractor's ability to perform the requested services, shall oversee and remain responsible and accountable for any functions and responsibilities delegated, and shall meet the subcontracting requirements as stated in 42 CFR 438.230(b) (1), (c)(1)(i)-(iii), (c)(2), (c)(3), Title 22 CCR Section 53867, and Title 22 CCR Section 53250, as well as those specified in APL 17-004 and this Contract. Contractor shall remain accountable for all functions and responsibilities that are delegated to Subcontractors. Nothing in this provision shall be construed to require that subcontracting Providers be enrolled as a Medi-Cal Provider.

A. Laws and Regulations

All Subcontracts shall be in writing and in accordance with the requirements of the 42 CFR 438.230(c)(1)(i)-(iii); Knox-Keene Health Care Services Plan Act of 1975; Health and Safety Code Section 1340 et seq.; Title 28 CCR Section 1300 et seq.; Welfare and Institutions Code Section 14200 et seq.; and Title 22 CCR Section 53800 et seq.; and other applicable federal and State laws and regulations.

B. Subcontract Requirements

Each Subcontract shall contain:

- 1) Specification of the services to be provided by the Subcontractor.
- 2) Specification that the Subcontract shall be governed by and

**Exhibit A, Attachment 6
PROVIDER NETWORK**

construed in accordance with all laws and applicable regulations governing this Contract.

- 3) Specification that the Subcontract or Subcontract amendments shall become effective only as set forth in Paragraph C, Departmental Approval – Non-Federally Qualified HMOs, or Paragraph D, Departmental Approval – Federally Qualified HMOs.
- 4) Specification of the term of the Subcontract, including the beginning and ending dates as well as methods of extension, renegotiation and termination.
- 5) Language comparable to Exhibit A, Attachment 8, Provision 12, Contracting & Non-Contracting Emergency Service Providers and Post-Stabilization for those Subcontractors at risk for non-contracting emergency services.
- 6) Subcontractor's agreement to submit reports as required by Contractor.
- 7) Specification that the Subcontractor shall comply with all monitoring provisions of this Contract and any monitoring request by DHCS.
- 8) Subcontractor's agreement to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of the Subcontract, 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, Program Terms and Conditions, Provision 21. Inspection Rights:
 - a) By DHCS, CMS, Department of Health and Human Services (DHHS) Inspector General, the Comptroller General, Department of Justice (DOJ), DMHC, or their designees.
 - b) At all reasonable times at the Subcontractor's place of business or at such other mutually agreeable location in California.
 - c) In a form maintained in accordance with the general standards applicable to such book or record keeping.
 - d) For a term of at least 10 years from the final date of the

**Exhibit A, Attachment 6
PROVIDER NETWORK**

Contract period or from the date of completion of any audit, whichever is later.

- e) Including all Encounter Data for a period of at least 10 years.
 - f) If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Subcontractor at any time.
 - g) Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Subcontractor from participation in the Medi-Cal program; seek recovery of payments made to the Subcontractor; impose other sanctions provided under the State Plan, and direct Contractor to terminate their Subcontract due to fraud.
- 9) Full disclosure of the method and amount of compensation or other consideration to be received by the Subcontractor from Contractor.
- 10) Subcontractor's agreement to maintain and make available to DHCS, upon request, copies of all sub-subcontracts and to ensure that all sub-subcontracts are in writing and require that the Sub-Subcontractor:
- a) Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Contract, available at all reasonable times for audit, inspection, examination, or copying by DHCS, CMS, or the DHHS Inspector General, the Comptroller General, and DOJ, or their designees.
 - b) Retain all records and documents for a minimum of 10 years from the final date of the Contract period or from the date of completion of any audit, whichever is later.
- 11) Subcontractor's agreement to assist Contractor in the transfer of care pursuant to Exhibit E, Attachment 2, Provision 15. Phaseout Requirements, in the event of Contract termination.
- 12) Subcontractor's agreement to assist Contractor in the transfer of care in the event of sub-subcontract termination for any reason.

**Exhibit A, Attachment 6
PROVIDER NETWORK**

- 13) Subcontractor's agreement to notify DHCS in the event the agreement with Contractor is terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached.
- 14) Subcontractor's agreement that assignment or delegation of the Subcontract will be void unless prior written approval is obtained from DHCS.
- 15) Subcontractor's agreement to hold harmless both the State and Members in the event Contractor cannot or will not pay for services performed by the Subcontractor pursuant to the Subcontract.
- 16) Subcontractor's agreement to timely gather, preserve and provide to DHCS, any records in the Subcontractor's possession, in accordance with Exhibit E, Attachment 2, Provision 26. Records Related to Recovery for Litigation.
- 17) Subcontractor's agreement to arrange interpreter services for Members at all Provider sites.
- 18) Subcontractor's right to submit a grievance and Contractor's formal process to resolve Provider Grievances.
- 19) Subcontractor's agreement to participate and cooperate in Contractor's Quality Improvement System.
- 20) If Contractor delegates Quality Improvement activities, Subcontract shall include those provisions stipulated in Exhibit A, Attachment 4, Provision 6. Delegation of Quality Improvement Activities.
- 21) Subcontractor's agreement to comply with all applicable requirements specified in: this Contract and subsequent amendments, Federal and State laws and regulations.
- 22) Pursuant to Health & Safety Code Section 1261, subcontractor's agreement by any subcontracting or sub-subcontracting health facility, if subcontractor is licensed pursuant to Health & Safety Code Section 1250, to permit a Member to be visited by a Member's domestic partner, the children of the Member's domestic partner, and the domestic partner of the Member's parent or child.
- 23) Subcontractor's agreement to provide Contractor with the disclosure statement set forth in Title 22 CCR Section 51000.35,

**Exhibit A, Attachment 6
PROVIDER NETWORK**

prior to commencing services under the Subcontract.

- 24) Subcontractor's agreement to revoke the delegation of activities or obligations, or specify other remedies in instances where DHCS or Contractor determine that the Subcontractor has not performed satisfactorily.
- 25) To the extent that the Subcontractor is responsible for the coordination of care for Members, Contractor's agreement to share with the Subcontractor any utilization data that DHCS has provided to Contractor, and the Subcontractor's agreement to receive the utilization data provided and use as they are able for the purpose of Member care coordination.
- 26) Contractor's agreement to inform the Subcontractor of prospective requirements added by DHCS to this Contract before the requirement would be effective, and Subcontractor's agreement to comply with the new requirements within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible.

C. Departmental Approval - Non-Federally Qualified HMOs

Except as provided in Exhibit A, Attachment 8, Provider Compensation Arrangements, Provision 6 regarding Federally Qualified Health Centers and Rural Health Clinics, a Provider or management Subcontract entered into by Contractor which is not a federally qualified HMO shall become effective upon approval by DHCS in writing, or by operation of law where DHCS has acknowledged receipt of the proposed Subcontract, and has failed to approve or disapprove the proposed Subcontract within 60 calendar days of receipt.

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

D. Departmental Approval - Federally Qualified HMOs

Except as provided in Exhibit A, Attachment 8, Provider Compensation Arrangements, Provision 6 regarding Federally Qualified Health Centers and Rural Health Clinics, Subcontracts entered into by Contractor which is

**Exhibit A, Attachment 6
PROVIDER NETWORK**

a federally qualified HMO shall be exempt from prior approval by DHCS and submitted to DHCS upon request.

E. Public Records

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

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

Subcontracts with FQHCs shall also meet Subcontract requirements of Provision 13 above and reimbursement requirements in Exhibit A, Attachment 8, Provision 6. In Subcontracts with FQHCs and RHCs where a negotiated reimbursement rate is agreed to as total payment, a provision that such rate constitutes total payment shall be included in the Subcontract.

15. Traditional and Safety-Net Providers Participation

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

16. Nondiscrimination In Provider Contracts

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

**Exhibit A, Attachment 6
PROVIDER NETWORK**

practitioners in the same specialty; or preclude Contractor from establishing measures that are designed to maintain quality of services and control costs and are consistent with Contractor's responsibilities to Members.

**Exhibit A, Attachment 7
PROVIDER RELATIONS**

1. Exclusivity

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

2. Provider Grievances, Appeals, and Disputes

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

3. Non-Contracting, Non-Emergency Provider Communication

Contractor shall maintain policies and procedures for arranging payment of claims to non-contracting, non-emergency Providers.

4. Contractor's Provider Manual

Contractor shall issue a provider manual to the contracting and subcontracting Providers of health care services that includes information and updates regarding Medi-Cal services, policies and procedures, statutes, regulations, telephone access and special requirements, and the Member Grievance, Appeal, and State Fair 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 Hearing, and representation rules at a Hearing;
- B. Member's right to file Grievances and Appeals and their requirements and timeframes for filing;
- C. Availability of assistance in filing;
- D. Toll-free numbers to file oral Grievances and Appeals; and
- E. Member's right to request continuation of benefits during an Appeal or State Hearing.

**Exhibit A, Attachment 7
PROVIDER RELATIONS**

Provider manuals shall include information about grievance and state hearing processes, procedures and timeframes, in accordance with Title 42 CFR Section 438.414.

5. Network Provider Training

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 relates to Medi-Cal Managed Care services, policies, procedures and any modifications to existing services, policies or procedures. Contractor shall conduct training for all Network Providers no later than 10 working days after Contractor places a newly contracted Network Provider on active status and shall complete the training within 30 calendar days of placing on active status. Contractor shall ensure that Network Provider training includes, but is not limited to, information on all Member rights specified in Exhibit A, Attachment 13, Member Services, including the right to full disclosure of health care information and the right to actively participate in health care decisions. Contractor shall ensure that ongoing training is conducted when deemed necessary by either Contractor or DHCS.

Contractor shall develop and implement a process to provide information to Network Providers and to train providers on a continuing basis regarding clinical protocols and evidenced-based practice guidelines and DHCS developed cultural awareness and sensitivity instructions for Seniors and Persons with Disabilities. 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.

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.

6. Submittal of Inpatient Days Information

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

**Exhibit A, Attachment 7
PROVIDER RELATIONS**

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 designated contact person responsible for coordinating services and who can be contacted 24-hours a day.
- C. Written instruction and 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 use to notify and inform Contractor when existing health plan emergency department protocols fail to ensure continuity of care.
- E. Procedures and protocols for emergency departments to use for Members who have been assessed and based upon that assessment determined to have a non-emergent condition.

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 an enrollee who is his or her patient: for the enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered, for any information the enrollee needs in order to decide among all relevant treatment options, for the risks, benefits, and consequences of treatment or non-treatment, for the enrollee'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 enter into a Subcontract if the compensation or other consideration which the Subcontractor shall receive under the terms of the Subcontract is determined by a percentage of the Contractor's payment from the State, unless DHCS objects. This provision shall not be construed to prohibit Subcontracts in which compensation or other consideration is determined on a capitation basis.

2. Capitation Payments

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

3. Physician Incentive Plan Requirements

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

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

4. Claims Processing

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

- A. Contractor shall comply with 42 USC Section 1396a(a)(37) and Health and Safety Code Sections 1371 through 1371.39.
- B. Contractor shall pay 90 percent of all clean claims from practitioners who

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

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

- C. Contractor shall maintain procedures for prepayment and post payment claims review, including review of data related to Provider, Member and Covered Services for which payment is claimed.
- D. Contractor shall maintain sufficient claims processing/tracking/payment systems capability to: comply with applicable State and federal law, regulations and Contract requirements, determine the status of received claims, and calculate the estimate for incurred and unreported claims.
- E. Contractor shall submit claims payment summary reports to DHCS on a quarterly basis as specified in Exhibit A, Attachment 2, Provision 2. Financial Audit Reports Paragraph B. 2).

5. Prohibited Claims

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

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.

6. 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, Contractor shall reimburse non-contracting FQHCs for services provided to Contractor's Members at a level and amount of payment that is not less than the Contractor makes for the same scope of services furnished by a Provider that is not a FQHC or RHC.

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

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

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

To the extent that American Indian Health Service Programs qualify as FQHCs or RHCs, the above reimbursement requirements shall apply to Subcontracts 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 subcontracted Provider.

C. American Indian Health Service Programs

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 subcontracted Provider as set forth in 42 CFR 438.14(c)(1).

2) For services provided on or after January 1, 2018 to Members who

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

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.

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

If there are no CNMs or CNPs in Contractor's Provider Network, Contractor shall reimburse non-contracting CNMs or CNPs for services provided to Members at no less than the applicable Medi-Cal Fee-For-Service (FFS) rates. If an appropriately licensed non-contracting facility is used, Contractor shall pay the facility fee. For hospitals, the requirements of Provision 12, Paragraph C. below apply. For birthing centers, the Contractor shall reimburse no less than the applicable Medi-Cal FFS rate.

8. Non-Contracting Family Planning Providers' Reimbursement

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

9. Sexually Transmitted Disease (STD)

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

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 may elect to 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.

10. 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.

11. 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. Contractor shall not be obligated to reimburse Providers other than local health departments unless they enter into an agreement with the Contractor.

12. 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. 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 enrollees primary care provider, the plan, or

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

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 CPT (Physician's Current Procedural Terminology) codes, unless a higher level is clearly supported by documentation, and for the facility fee and diagnostic services such as laboratory and radiology.
- 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 4. 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 an Emergency Medical Condition solely on the basis of lists of diagnoses or symptoms.
- G. In accordance with Title 28 CCR 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

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

authorization within the required timeframe, the authorization will be deemed approved. Contractor is financially responsible for post-stabilization service payment as provided in subparagraph C above.

- 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 Network 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 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 plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria of 422.133(c)(3) is met.
- J. Contractor's financial responsibility for post-stabilization care services it has not pre-approved ends when a plan physician with privileges at the treating hospital assumes responsibility for the Member's care, a plan physician 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-

Exhibit A, Attachment 8
PROVIDER COMPENSATION ARRANGEMENTS

stabilization services 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 (W & I 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 22 CCR 51536 shall not have any effect on payments made by Contractor pursuant to this Paragraph K.

13. 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 subcontracted providers to report, PPCs in the form and frequency required by APL 17-009.

14. Prohibition Against Payment of Excluded Providers

In accordance with Section 1903(i)(2) of the Act, Contractor shall not pay any

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

amount for any Covered Service or item, other than Emergency Services, to an excluded provider as defined in Exhibit E, Attachment 2, Provision 27, 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.

**Exhibit A, Attachment 9
ACCESS AND AVAILABILITY**

1. General Requirement

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

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

2. Existing Patient-Physician Relationships

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

3. Access Requirements

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

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.

- 1) **Appropriate Clinical Timeframes:**
Contractor shall ensure that Members are offered appointments for covered health care services within a time period appropriate for their condition.
- 2) **Standards for Timely Appointments:**

Exhibit A, Attachment 9
ACCESS AND AVAILABILITY

Members must be offered appointments within the following timeframes:

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

3) Shortening or Expanding Timeframes

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

4) Provider Shortage

Contractor shall be required to arrange for a Member to receive timely care as necessary for their health condition if timely appointments within the time and distance standards required in Attachment 6, Provision 7 of this contract are not available. Contractor shall refer Members to, or assist Members in locating, available and accessible contracted providers in neighboring service areas for obtaining health care services in a timely manner.

B. First Prenatal Visit

Contractor shall ensure that the first prenatal visit for a pregnant Member will be available within 10 business days upon request.

C. Waiting Times

**Exhibit A, Attachment 9
ACCESS AND AVAILABILITY**

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

D. 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.

E. Urgent Care

Contractor shall ensure that a Member needing Urgent Care is seen within 24 hours upon request.

F. After Hours Calls

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

G. Specialty Services

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

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

Unless prohibited by law, Contractor shall arrange for the timely referral and coordination of Covered Services to which the Contractor or Subcontractor has religious or ethical objections to perform or otherwise support and shall demonstrate ability to arrange, coordinate and ensure provision of services.

5. Standing Referrals

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

- A. Contractor shall have in place a procedure for a Member to receive a standing referral to a Specialist if the primary care physician determines, in consultation with the Specialist and Contractor's Medical Director or the

**Exhibit A, Attachment 9
ACCESS AND AVAILABILITY**

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 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.

6. Emergency Care

**Exhibit A, Attachment 9
ACCESS AND AVAILABILITY**

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

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

7. Nurse Midwife and Nurse Practitioner Services

Contractor shall meet federal requirements for access and reimbursement for 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. If Members do not have access to CNM or CNP services within Contractor's provider network, Contractor shall inform Members that they have a right to obtain out-of-Network CNM or CNP services.

8. 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 enables Member 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).

1) Informed Consent

Contractor shall ensure that Members are informed of the full array

**Exhibit A, Attachment 9
ACCESS AND AVAILABILITY**

of covered contraceptive methods and that informed consent is obtained from Members for 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 in MMCD Policy Letter 96-09 for each sexually transmitted disease, if medically indicated.
- e) Screening, testing, and counseling of at risk individuals for HIV and referral for treatment.
- f) Follow-up care for complications associated with contraceptive methods provided or prescribed by the family planning Provider.
- g) Provision of contraceptive pills, devices, and supplies.
- h) Tubal ligation.
- i) Vasectomies
- j) Pregnancy testing and counseling.

B. Sexually Transmitted Diseases (STDs)

Contractor shall provide access to STD services without Prior Authorization to all Members both within and outside its Provider Network.

**Exhibit A, Attachment 9
ACCESS AND AVAILABILITY**

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 (1) office visit per STD episode for the purposes of:

- 1) Diagnosis and treatment of vaginal discharge and urethral discharge.
- 2) Those STDs that are amenable to immediate diagnosis and treatment, and this includes syphilis, gonorrhea, chlamydia, herpes simplex, chancroid, trichomoniasis, human papilloma virus, non-gonococcal urethritis, lymphogranuloma venereum and granuloma inguinale.
- 3) Evaluation and treatment of pelvic inflammatory disease.

Contractor shall provide follow-up care.

C. HIV Testing and Counseling

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

D. Minor Consent Services

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

- 1) Sexual assault, including rape.
- 2) Drug or alcohol abuse for children 12 years of age or older.
- 3) Pregnancy.
- 4) Family planning.
- 5) STDs and HIV/AIDS in children 12 years of age or older.

**Exhibit A, Attachment 9
ACCESS AND AVAILABILITY**

E. Immunizations

Members may access LHD for immunizations. Contractor shall, upon request, provide updated information on the status of Members' immunizations to LHDs.

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).

9. Changes in Availability or Location of Covered Services

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

10. Access for Disabled Members

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

11. Civil Rights Act of 1964

Contractor shall ensure compliance with Title VI of the Civil Rights Act of 1964 and any implementing regulations (42 USC Section 2000d and 45 CFR Part 80) that prohibit recipients of federal financial assistance from discriminating against

**Exhibit A, Attachment 9
ACCESS AND AVAILABILITY**

persons based on race, color, religion, or national origin.

12. Cultural and Linguistic Services Program

Contractor shall have a Cultural and Linguistic Services Program that monitors, evaluates, and takes 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 requirements stipulated below.

A. Written Description

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

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

B. Linguistic Capability of Employees

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

C. Group Needs Assessment (GNA)

Contractor shall ensure that the Health Education, Cultural and Linguistic GNA, as described in Exhibit A, Attachment 10, Provision 8, Paragraph

**Exhibit A, Attachment 9
ACCESS AND AVAILABILITY**

A.3) includes identification of the cultural and linguistic needs of members. Contractor shall demonstrate, upon request by the State, how the GNA findings and conclusions are utilized by the plan to provide contractually required cultural and linguistic services for members.

D. Cultural Competency Training

Contractor shall provide cultural competency, sensitivity, or diversity training for staff, 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 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.

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

E. Program Implementation and Evaluation

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

13. Linguistic Services

- A. Contractor shall ensure equal access to health care services for its Members without regards to a Member's proficiency in the English language. Contractor will provide interpreter services adequate to communicate the medical, social, and psychological issues of its Members when necessary.
- B. Contractor shall comply with Title 22 CCR Section 53853(c) and (d), and ensure that all monolingual, non-English-speaking, or LEP Members receive 24-hour oral interpreter services at all key points of contact, as defined in Paragraph E of this provision, either through interpreters or telephone language services.

Exhibit A, Attachment 9
ACCESS AND AVAILABILITY

- C. Contractor shall comply with 42 CFR 438.10(d)(4) and provide, at minimum, the following linguistic services at no cost to Medi-Cal Members:
- 1) Oral Interpreters, signers, or bilingual Providers and Provider staff at all key points of contact. These services shall be provided in all languages spoken by all Medi-Cal Members 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, if applicable, 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 GNA.
 - 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.
- D. Contractor shall provide translated Member information to the following population groups within its Service Area as determined by DHCS:
- 1) A population group of mandatory 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 mandatory 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 (2) contiguous ZIP codes.
- E. Key points of contact include:
- 1) Medical care settings: telephone, advice and urgent care

**Exhibit A, Attachment 9
ACCESS AND AVAILABILITY**

transactions, and outpatient encounters with health care Providers including pharmacists.

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

14. Community Advisory Committee or Committees (CAC)

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

15. Healthcare Surge Events

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

16. Out-of-Network Providers

- A. If Contractor's Network is unable to provide necessary medical services covered under the contract to a particular Member, Contractor must adequately and timely cover these services out-of-Network for the Member, for as long as the entity is unable to provide them. Out-of-Network Providers must coordinate with the entity with respect to payment. Contractor must ensure that cost to the Member is no greater than it would be if the services were furnished within the Network.
- B. 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

**Exhibit A, Attachment 9
ACCESS AND AVAILABILITY**

Contractor or Medi-Cal FFS rates, whichever is higher, in accordance with W&I Code, 14182(b)(13) and (14). An ongoing relationship shall be determined by the Contractor identifying a link between a newly enrolled SPD beneficiary and an Out-of-Network Provider using FFS utilization data provided by DHCS.

- C. 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).

**Exhibit A, Attachment 10
COVERED SERVICES**

1. Covered Services

- A. Contractor shall provide or arrange for Members all Medically Necessary Covered Services and other services required in this Contract. Covered Services are those services set forth in Title 22 CCR Chapter 3 Article 4, beginning with Section 51301, 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 Medi-Cal Fee-For-Service. 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. 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 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

**Exhibit A, Attachment 10
COVERED SERVICES**

or substance use disorder benefits.

- 2) Contractor shall provide referrals for all non-covered mental health and substance use disorder services.

2. Medically Necessary Services

For purposes of this Contract, the term “Medically Necessary” will include all Covered Services that are reasonable and necessary to protect life, prevent illness or disability, alleviate severe pain through the diagnosis or treatment of disease, illness or injury, achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity per Title 22 CCR Section 51303(a) and 42 CFR 438.210(a)(5).

When determining the Medical Necessity of Covered Services for a Medi-Cal beneficiary under the age of 21, “Medical Necessity” is expanded to include the standards set forth in 42 USC Section 1396d(r), and W & I Code Section 14132 (v).

3. Initial Health Assessment (IHA)

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

- A. Contractor shall cover and ensure the provision of an IHA (comprehensive history and physical examination) in conformance with Title 22 CCR Section 53851 (B)(1) and 53910.5(a)(1) to each new Member within 120 days of enrollment.
- B. Contractor shall ensure that the IHA includes the IHEBA as described in Exhibit A, Attachment 10, Provision 8, Paragraph A. using an age appropriate DHCS-approved assessment tool.
- C. Contractor is responsible for assuring that arrangements are made for follow-up services and plan of care that reflect the findings and risk factors determined during the IHA and IHEBA .
- D. Contractor shall ensure that Member’s completed IHA and IHEBA tool are contained in the Member’s Medical Record and available during

**Exhibit A, Attachment 10
COVERED SERVICES**

subsequent health visits.

- E. Contractor shall make repeated attempts, if necessary, to contact a Member and schedule an IHA.
- 1) Contractor shall make at least three (3) documented attempts that demonstrate Contractor's unsuccessful efforts to contact a Member and schedule an IHA. Contact methods must include at least one (1) telephone and one (1) mail notification.
 - 2) Contractor must document all attempts to perform an IHA at subsequent office visit(s) until all components of the IHA are completed.

4. Health Risk Stratification and Assessment for SPD Beneficiaries

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

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

Contractor shall cover and ensure the provision of screening, preventive and Medically Necessary diagnostic and treatment services for Members under 21 years of age, including services listed under 42 USC Section 1396d(r), and Welfare and Institutions Code, Section 14132 (v), unless otherwise excluded under this Contract. Contractor shall inform Members that EPSDT services are available for Members under 21 years of age, as well as how to access services. Contractor shall ensure that appropriate diagnostic and treatment services are initiated as soon as possible but no later than 60 calendar days following either a preventive screening or other visit that identifies a need for follow-up.

A. Provision of IHAs for Members under Age 21

- 1) For Members under the age of 18 months, Contractor shall ensure the provision of an IHA within 120 calendar days following the date of enrollment or within the most recent periodicity timelines established by the American Academy of Pediatrics (AAP) for ages two (2) and younger, whichever is less.

**Exhibit A, Attachment 10
COVERED SERVICES**

- 2) For Members 18 months of age and older upon enrollment, Contractor is responsible to ensure an IHA is performed within 120 calendar days of enrollment.
- 3) Contractor shall ensure that performance of the California Child Health and Disability Prevention (CHDP) age appropriate assessments due for each Member under 21 years of age at the time of enrollment is completed as part of the IHA. The IHA must include, or arrange for provision of, or arrangement for all immunizations necessary to ensure that the child is up-to-date. See PL 13-001 for specific IHEBA requirements.
- 4) Contractor shall ensure that the IHA includes the age-appropriate IHEBA, as described in Exhibit A, Attachment 10, Provision 8, Paragraph A.

B. Preventive Services for Members under Age 21

- 1) Contractor shall provide preventive services for all Members under 21 years of age as specified by the most recent AAP periodicity schedule (Bright Futures guidelines) and anticipatory guidance as outlined in the AAP Bright Futures periodicity schedule. Contractor shall ensure that these preventive health visits include age-specific assessments and services required by the CHDP program. When the AAP periodicity examination schedule occurs more frequently than the CHDP examination schedule, Contractor shall ensure that the AAP periodicity schedule is followed and that the scheduled assessment and services include all content required by the CHDP for the lower age nearest to the current age of the child.
- 2) Contractor shall ensure that routine preventive health visits for Members under 21 years of age include the age-appropriate IHEBA, as described in Exhibit A, Attachment 10, Provision 8, Paragraph A.
- 3) Where a request is made for children's preventive services by the Member, the Member's parent(s) or guardian, or through a referral from the local CHDP program, an appointment shall be made for the Member to be examined within two (2) weeks of the request.
- 4) At each non-emergency Primary Care Encounter with Members under 21 years of age, the Member (if an emancipated minor or age 18 or older) or the parent(s) or guardian of the Member shall be

**Exhibit A, Attachment 10
COVERED SERVICES**

advised of the preventive services due and available from Contractor, if the Member has not received preventive services in accordance with the most recent CHDP preventive standards. Documentation shall be entered in the Member's Medical Record which shall indicate the receipt of preventive services in accordance with the CHDP standards or of voluntary refusal of these services. A declination of services may be in the form of a signed statement by the Member (if an emancipated minor or age 18 or older) or the parent(s) or guardian of the Member, or dated documentation of Member's response to an in-person or telephone contact. Declination of services shall be noted in the Member's Medical Record. A nonresponse may be documented via the absence of a form or recipient response.

- 5) The Confidential Screening/Billing Report form, PM 160, or any other system or format implemented by DHCS, shall be used to report all children's preventive services Encounters, in addition to the Encounter Data submittal required in Exhibit A, Attachment 3, Management Information System Capability, Provision 2, Encounter Data Submittal.

Contractor shall submit completed forms to DHCS and to the local children's preventive services program within the timeframe specified by DHCS.

C. Immunizations for Members under Age 21

- 1) Contractor shall 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). Upon Federal Food and Drug Administration (FDA) approval of any vaccine for childhood immunization, Contractor shall develop policies and procedures for the timely provision and administration of the vaccine. Policies and procedures shall be developed within thirty calendar days of the approval date of a vaccine. Contractor shall cover and ensure the provision of age and risk appropriate immunizations regardless of whether the vaccine has been incorporated into the Vaccines for Children (VFC) program. Policies and procedures must be in accordance with any Medi-Cal Fee-for-Service guidelines issued prior to final ACIP recommendations.
- 2) If immunizations cannot be given at the time of the visit, the Member must be instructed about how to obtain necessary

**Exhibit A, Attachment 10
COVERED SERVICES**

immunizations or a scheduled appointment must be made and documented.

- 3) Contractor shall document attempts to provide immunizations. Documentation shall be entered in to Member's Medical Record to indicate the receipt of immunizations in accordance with the ACIP standards or of voluntary refusal of these services. A declination of services may be in the form of a signed statement by the Member (if an emancipated minor or age 18 or older) or the parent or guardian of the Member, or a dated documentation of Member's response to an in-person or telephone contact. Declination of services shall be noted in the Member's Medical Record. A nonresponse may be documented via the absence of a form or recipient response. Additional attempts to provide the immunization at subsequent member office visit(s) must be documented.
- 4) Contractor shall provide information to all Network Providers regarding the Vaccines for Children (VFC) Program.

D. Blood Lead Screens

- 1) Contractor shall cover and ensure the provision of a blood lead screening test to Members at ages one (1) and two (2) in accordance with Title 17 CCR Division 1 Chapter 9, commencing with Section 37000. Contractor shall document and appropriately follow up on blood lead screening test results.
- 2) Contractor shall make reasonable attempts to ensure the blood lead screen test is provided and shall document attempts to provide the test in the Member's Medical Record. Documentation shall be entered in to Member's Medical Record to indicate the receipt of blood lead screen testing and test results, or of voluntary refusal of these services. A declination of services may be in the form of a signed statement by the parent or guardian of the Member, or a dated documentation of parent's or guardian's response to an in-person or telephone contact. Declination of services shall be noted in the Member's Medical Record. A nonresponse may be documented via the absence of a form or recipient response.

E. Screening for Chlamydia for Members Age 25 and younger

- 1) Contractor shall screen all sexually active females 25 years of age and younger for chlamydia in accordance with the United States

**Exhibit A, Attachment 10
COVERED SERVICES**

Preventive Services Taskforce (USPSTF) recommendations.
Follow up of positive results must be documented in the Medical Record.

- 2) Contractor shall make reasonable attempts to contact the appropriately identified Members and provide screening for chlamydia.
- 3) Documentation shall be entered in to Member's Medical Record to indicate the receipt of chlamydia screening and test results, or of parent, guardian or Member's voluntary refusal of these services. A minor must be at least 12 years of age to request testing or treatment for sexually transmitted diseases, including HIV/AIDS (California Family Code, Section 6926). A declination of services may be in the form of a signed statement by the parent or guardian of the Member or the Member (if an emancipated minor or age 18 or older), or a dated documentation of parent's or guardian's response to an in-person or telephone contact. Declination of services shall be noted in the Member's Medical Record. A nonresponse may be documented via the absence of a form or recipient response.

F. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services

For Members under the age of 21 years, Contractor shall provide or arrange and pay for EPSDT services, unless otherwise excluded in this Contract. Covered Services include all Medically Necessary services, as defined in 42 USC Section 1396d(r), and Welfare and Institutions Code, Section 14132 (v). Covered Services shall include case management as well as Targeted Case Management services as defined in Attachment 11, Provision 3 of this Contract.

Contractor is required to 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 Covered Services that Contractor is responsible for providing pursuant to this Contract.

Contractor shall also ensure that appropriate EPSDT services are initiated in a timely manner, as soon as possible but no later than 60 calendar days following either a preventive screening or other visit that identifies a need for follow-up.

**Exhibit A, Attachment 10
COVERED SERVICES**

Covered Services do not include California Children's Services (CCS) pursuant to Exhibit A, Attachment 11, Provision 9, regarding CCS, or mental health services pursuant to Provision 8 below, regarding Mental Health Services. Contractor shall determine the Medical Necessity of EPSDT services using the criteria established in 142 USC Section 1396d(r), and Welfare and Institutions Code, Section 14132 (v).

G. Behavioral Health Treatment (BHT) Services

For Members under 21 years of age diagnosed with Autism Spectrum Disorder (ASD), or for Members under 3 years of age with a rule out or provisional diagnosis, Contractor shall cover Medically Necessary BHT services as defined in the federally approved State Plan, and in accordance with Health and Safety Code sections 1374.72 and 1374.73, 28 California Code of Regulations 1300.74.72, APL 15-019, and APL 15-025 to the extent that they are consistent with the State Plan. APLs superseding APL 15-019 and APL 15-025 that clarify the delivery of BHT services shall be incorporated herein by this reference and become part of this Contract as of their effective date.

- 1) Contractor shall provide Medically Necessary BHT services as stated in the Member's treatment plan and/or continuation of BHT services under continuity of care with the Member's BHT Provider.
- 2) For Members 3 years or older, Contractor shall require a Comprehensive Diagnostic Evaluation before Members receive BHT services.
- 3) BHT services must be based upon a treatment plan that is reviewed no less than every six (6) months by a qualified autism service Provider as defined by Health and Safety Code Section 1374.73(c)(3) and by the federally approved State Plan.
- 4) Contractor shall provide continuity of care for Members diagnosed with ASD as stated below and in accordance with this Section F.
 - a) For Members who had received BHT through a regional center prior to September 15, 2014, Contractor shall not provide BHT services until such time as the Member may be safely transitioned into Contractor's Provider Network in accordance with the BHT services transition plan approved by DHCS and the Department of Developmental Services (DDS). If a Member, or a Member's parent or legal guardian, chooses to access BHT services from Contractor's Network

**Exhibit A, Attachment 10
COVERED SERVICES**

Provider prior to the transition of regional center clients to the Contractor for BHT services, Contractor shall provide Medically Necessary BHT services from Contractor's Network Provider.

- b) If Members received BHT services outside of Contractor's Network prior to September 15, 2014, and the Member or the Member's parent or legal guardian request continued access to their existing BHT Provider, Contractor shall ensure continuity of care in accordance with APL 15-019 and APL 15-025.

Contractor must offer continuity of care with an out-of-Network BHT Provider if all of the following conditions are met:

- i. The Member has an existing relationship with a qualified autism service Provider. An existing relationship means the Member has seen an out-of-Network BHT Provider at least one time during the six (6) months prior to Contractor assuming responsibility of BHT services from the regional center or the date of the Member's initial enrollment with Contractor if enrollment occurred on or after September 15, 2014;
 - ii. The Provider can agree to Contractor's rate or the Medi-Cal FFS rate, whichever is higher, for the appropriate BHT service;
 - iii. The Provider does not have any documented quality of care issues that would cause exclusion from Contractor's Network;
 - iv. The Provider is a qualified Provider under Health & Safety Code Section 1374.73 and the approved State Plan; and
 - v. The Provider supplies Contractor with all relevant treatment information, for purposes of determining medical necessity, as well as a current treatment plan, as long as it is allowable under federal and state privacy laws and regulations.
- c) Contractor shall continue to authorize Medically Necessary

**Exhibit A, Attachment 10
COVERED SERVICES**

BHT services in accordance with the Member's treatment plan at the time of the request for continuity of care during the continuity of care period.

- d) Contractor's Network Provider may update the BHT treatment plan upon completion of the assessment and discontinue BHT services if the evaluation determines that the authorization of BHT services is not Medically Necessary.
- 5) Contractor shall provide all necessary Member treatment information to the Member's regional center to enable care coordination, as permitted by federal and State law, APL 15-022, and this Contract.
- 6) 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 ASD, as permitted by federal and State law, and specified by DHCS in APL 15-022. If Contractor is unable to enter into an MOU, Contractor shall inform DHCS why agreement with the regional center was not reached and demonstrate that a good faith effort was made by Contractor to enter into an MOU with the regional center.

6. Services for Adults Twenty-One (21) Years of Age and Older

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

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

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

**Exhibit A, Attachment 10
COVERED SERVICES**

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

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

For all Adults, Contractor shall ensure that the IHA includes the IHEBA, as described in Exhibit A, Attachment 10, Provision 8, Paragraph A.

B. Adult Preventive Services

Contractor shall cover and ensure all preventive and Medically Necessary diagnostic and treatment services for adult Members. Preventive services should be provided in accordance with evidence based guidelines.

- 1) Contractor shall ensure that plans provide at a minimum preventive services based on 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 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." The presence of risk factors and medical conditions will determine whether further follow-up, diagnostic, and/or treatment services are necessary. The preventive services identified in the IHA shall be offered at the frequency required by the USPSTF Guide to Clinical Preventive Services.
- 2) Contractor shall cover and ensure the provision of all Medically Necessary services based on the findings or risk factors identified in the IHA or during routine, urgent, or emergent health care visits. Contractor shall ensure that these services are initiated as soon as possible but no later than 60 calendar days following discovery of a problem requiring follow up.
- 3) Contractor shall ensure that adult preventive services includes the IHEBA, as described in Exhibit A, Attachment 10, Provision 8, Paragraph A.

C. Adult Immunizations

**Exhibit A, Attachment 10
COVERED SERVICES**

- 1) Contractor is responsible for assuring that all adults are fully immunized. Contractor shall ensure the timely provision of vaccines in accordance with the most recent recommendations of the Advisory Council on Immunization Practices if the vaccine is a Medi-Cal covered benefit.
- 2) Contractor shall develop policies and procedures for the timely provision and administration of vaccines. Policies and procedures shall be developed within 30 calendar days of Medi-Cal coverage of the immunization.
- 3) Contractor shall cover and ensure the provision of age and risk appropriate immunizations in accordance with the findings of the IHA, other preventive screenings, or the presence of risk factors identified in the IHEBA.
- 4) If the Member refuses the immunization, proof of voluntary refusal of the immunization by the Member or guardian of the Member, if appropriate, shall be documented in the Member's Medical Record. If the responsible party refuses to sign this statement, the refusal shall be documented in the Member's Medical Record. Additional attempts to provide the immunization should be made and documented at subsequent member office visit(s).

D. Screening for Chlamydia for Members Age 25 and younger

- 1) Contractor shall screen all sexually active females 25 years of age and younger for chlamydia in accordance with USPSTF recommendations. Follow up of positive results must be documented in the Medical Record.
- 2) Contractor shall make reasonable attempts to contact the identified Members and provide screening for chlamydia. Contractor shall document unsuccessful attempts to contact a Member and screen for chlamydia.
- 3) If the Member refuses screening for chlamydia, proof of voluntary refusal of the test by the Member or guardian of the Member, if appropriate, shall be documented in the Member's Medical Record. If the responsible party refuses to sign this statement, the refusal shall be documented in the Member's Medical Record.

7. Perinatal Services

**Exhibit A, Attachment 10
COVERED SERVICES**

A. Prenatal Care

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

B. Risk Assessment

Contractor shall implement a comprehensive risk assessment for all pregnant 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 and individualized care plan shall be maintained as part of the permanent obstetrical record and shall include medical/obstetrical and nutrition, health education, and psychosocial risk assessment components. The comprehensive risk assessments shall be administered at the initial prenatal visit, once each trimester thereafter and at the postpartum visit. Risks identified shall be followed up by appropriate interventions, which must be documented with appropriate follow-up in the Medical Record.

C. Referral to Specialists

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

8. Services for All Members

A. Health Education

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

**Exhibit A, Attachment 10
COVERED SERVICES**

management, and supervision of the health education system by a qualified, full-time health educator. Contractor shall maintain the organization and staffing to ensure successful implementation and maintenance of an effective health education system. Health education program activities must be coordinated and integrated with the Contractor's overall health care and quality improvement plan.

- 3) Contractor shall conduct a Health Education, Cultural and Linguistic Group Needs Assessment (GNA) to identify the health education, cultural and linguistic needs of Members and utilize the findings for continuous development and improvement of contractually required health education programs and services. Contractor shall use multiple, reliable data sources, methodologies, techniques, and tools to conduct the GNA. A GNA shall be conducted for the entire Service Area and shall be completed within 12 months from the commencement of operations and completed every five (5) years thereafter. For contracts existing at the time this provision becomes effective, the next GNA will be required at a time within this five (5) year period, to be determined by DHCS.
 - a) Contractor shall submit a GNA Summary Report to DHCS at the completion of each GNA. The Summary Report shall include: objectives; methodology; data sources; survey instruments; findings and conclusions; program and policy implications; and references. Findings and conclusions must include the following information for Members: demographic profile; related health risks, problems and conditions; related knowledge, attitudes and practices including cultural beliefs and practices; perceived health education needs including learning needs; preferred methods of learning and literacy level; and culturally competent community resources.
 - b) Contractor shall prepare a GNA Annual Update (every year) and shall maintain, and have available for DHCS review. The GNA Annual Update shall include any updated objectives, methodology, data sources, survey instruments, findings and conclusions; program and policy implications, and references. Findings and conclusions must include the following updated information with an analysis of changes and trends:
 - i. Demographic profile of Contractor's Medi-Cal membership;

**Exhibit A, Attachment 10
COVERED SERVICES**

- ii. Health risks, problems and conditions, and health disparities among Members;
- iii. Health education needs, cultural and linguistic needs; and
- iv. Culturally competent community resources.

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

- 4) Contractor shall ensure, and maintain documentation to demonstrate that the findings described in the GNA Summary Report and the GNA Annual Update, as well as other relevant information, are used to establish health education program priorities and appropriate levels and types of intervention for specific health issues and target populations. Contractor shall review the health education system annually to ensure appropriate allocation of health education resources based upon needs assessment findings, program evaluation results, and other program data.
- 5) Contractor shall ensure the organized delivery of health education programs and services, at no charge for Members, using a variety of educational strategies, methods and materials that are appropriate for the Member population and effective in achieving behavioral change for improved health. Contractor shall ensure that all health education information and materials are provided to Members at no higher than a 6th grade reading level, unless otherwise approved by DHCS, and are provided in a manner and form that are easily understood and culturally and linguistically appropriate for the intended audience.
- 6) Contractor shall provide health education programs and services directly and/or through subcontractors that have expertise in delivery of health education programs and services. Contractor shall conduct targeted outreach to promote optimal program use and participation by Members.
- 7) Contractors shall maintain a health education system that provides

**Exhibit A, Attachment 10
COVERED SERVICES**

educational interventions addressing the following health categories and topics and ensure that these programs are available and accessible to Members upon referral by providers and also upon the Member's request.

- a) **Effective use of Managed Health Care Services:**
Educational interventions designed to assist Members to effectively use the managed health care system, preventive and primary healthcare services, obstetrical care, and health education services; and appropriately use complementary and alternative care.
 - b) **Risk-Reduction and Healthy Lifestyles:** Educational interventions designed to assist Members to modify personal health behaviors, achieve and maintain healthy lifestyles, and promote positive health outcomes, including programs for tobacco use and cessation; alcohol and drug use; injury prevention; prevention of sexually transmitted diseases, HIV/AIDS, and unintended pregnancy; nutrition, weight control, and physical activity; and parenting.
 - c) **Self-Care and Management of Health Conditions:**
Educational interventions designed to assist Members to learn and follow self-care regimens and treatment therapies for existing medical conditions, chronic diseases or health conditions, including programs for pregnancy, asthma, diabetes, and hypertension.
- 8) Contractor shall ensure that Members receive health education services as part of preventive and primary health care visits. Contractor shall ensure that health risk behaviors, health practices and health education needs related to health conditions are identified, and that educational interventions, including counseling and referral for health education services, are conducted and documented in the Member's Medical Record. Contractor shall ensure that medical providers use the IHEBA tool and other relevant clinical evidence as part of the basis for identifying Members' health education needs and conducting educational intervention. Contractor shall provide resource information, educational materials and other program resources to assist providers to provide effective health education services for Members.
- 9) Contractor shall ensure that all new Members complete the IHEBA

**Exhibit A, Attachment 10
COVERED SERVICES**

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, but no later than their next scheduled health screening exam.

Contractor shall ensure that:

- a) The Staying Healthy Assessment (DHCS Form 7098) and bilingual translations, or alternative tools approved by DHCS, are used by Primary Care Providers to satisfy the IHEBA requirement;
- b) The IHEBA is administered and reviewed by the Primary Care Provider during an office visit;
- c) The IHEBA is reviewed at least annually by the Primary Care Provider with Members who present for a scheduled visit;
- d) The IHEBA is re-administered by the Primary Care Provider at the appropriate age-intervals utilized by the Staying Healthy Assessment (0-3 years, 4-8 years, 9-11 years, 12-17 years, and 18 years and older). This should occur at the patient's first scheduled health screening exam upon changing into the next age group.
- e) The IHEBA requires documentation and follow-up at initial and subsequent visits, of risk factors identified and addressed (brief counseling or referral to appropriate health education services) date and Primary Care Provider's signature or initials.
- f) The completed IHEBA tool is included along with the medical history and problem list as a permanent part of the Member's Medical Record. Documentation shall be entered in the Member's Medical Record which shall indicate the voluntary refusal to complete the IHEBA. A declination of services may be in the form of a signed statement by the Member (if an emancipated minor or age 18 or older) or the parent(s) or guardian of the Member, or dated documentation of Member's response to an in-person or telephone contact. Declination of services shall be noted in the Member's Medical Record. A nonresponse may be documented via the absence of a form or recipient response.

**Exhibit A, Attachment 10
COVERED SERVICES**

- g) Assistance is provided to Members in completing the assessment tool, if needed.
- h) Interventions are conducted and arrangements are made for follow-up services to address the needs identified by the IHEBA.

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

- 10) Contractor shall ensure education and training of contracting medical providers, practitioners, and Allied Health Care Personnel to support delivery of effective health education services for Members. Education and training must cover at least the following topics:
 - a) IHEBA requirements, use and documentation;
 - b) Techniques to enhance effectiveness of provider/patient interaction
 - c) Health plan and community health education resources available and procedures for referring individual Members to appropriate services;
 - d) Health education requirement standards, guidelines and monitoring; and,
 - e) GNA findings.

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

- 11) Contractor shall adopt and maintain appropriate health education program standards/guidelines and policies/procedures, and conduct appropriate levels of evaluation, e.g. formative, process, impact and outcome evaluation, to ensure access, availability and effectiveness in achieving health education program goals and

**Exhibit A, Attachment 10
COVERED SERVICES**

objectives. Contractor shall maintain documentation that demonstrates effective implementation of all DHCS health education requirements under this Contract.

- 12) Contractor shall monitor the performance of subcontractors that deliver health education programs and services to Members, and implement strategies to improve performance and effectiveness.
- 13) Contractor shall monitor access and availability of health education programs and services, and implement strategies to remove barriers to Member participation including, but not limited to, distance barriers (program location), availability barriers (frequency and timing of program offerings), and cultural and linguistic barriers.
- 14) Contractor shall cover and ensure provision of comprehensive case management including coordination of care services as described in Exhibit A, Attachment 11.
- 15) The Health Information Form (HIF)/Member Evaluation Tool (MET). Contractor shall use data from a Health Information Form (HIF)/Member Evaluation Tool (MET) or other DHCS approved tool for this purpose, to help identify newly enrolled SPD Members who may need expedited services. In accordance with 42 CFR 438.208(b), Contractor shall, at a minimum, comply with the following:
 - a) 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.
 - b) Within 90 days of each new Member's effective date of enrollment:
 - i. 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.
 - ii. Conduct an initial screening of the Member's needs as identified in the HIF/METs received. To meet this

**Exhibit A, Attachment 10
COVERED SERVICES**

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 Coordination of Care.

- c) 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.

B. Hospice Care

- 1) Contractor shall cover and ensure the provision of hospice care services in accordance with Section 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 be provided with, or to have payment made for covered services that are related to the treatment of that member's condition for which a diagnosis of terminal illness has been made.

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

- 2) Admission to a nursing facility of a Member who has elected covered hospice services, as described in 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 services regardless of the Member's expected or actual length of stay in a nursing facility.

C. Vision Care – Lenses

**Exhibit A, Attachment 10
COVERED SERVICES**

Contractor shall cover and ensure the provision of Vision Care services as specified in Title 22 CCR Sections 51306, 51317, 51518, 51519, 51519.1, and 51519.2, as appropriate for all Members, with the exception that Contractor shall arrange for the fabrication of optical lenses for Members through Prison Industry Authority (PIA) optical laboratories. Contractor shall cover the cost of dispensing of the lenses for Members. DHCS will reimburse PIA for the fabrication of the ophthalmic lenses in accordance with the Interagency Agreement between DHCS and PIA.

D. Mental Health and Substance Use Disorder Services

- 1) Contractor shall cover Outpatient Mental Health Services that are within the scope of practice of Primary Care Providers and mental health care Providers, in accordance with the Outpatient Mental Health Services requirements as defined in Exhibit E, Attachment 1, Definitions. Contractor's policies and procedures shall define and describe what services are to be provided by Primary Care Providers. In addition, Contractor shall cover and ensure the provision of psychotherapeutic drugs prescribed by its Primary Care Providers or other mental health care professionals, except those specifically excluded in this Contract as stipulated below.
- 2) Contractor shall cover all Medically Necessary Covered Services for the Member, including the following services:
 - a) Emergency room professional services, except services provided by psychiatrists, psychologists, licensed clinical social workers, marriage, family and child counselors, or other Specialty Mental Health Providers.
 - b) Facility charges for emergency room visits which do not result in a psychiatric admission.
 - c) All laboratory and radiology services when these services are necessary for the diagnosis, monitoring, or treatment of a Member's mental health condition.
 - d) Emergency Medical Transportation services necessary to provide access to all Medi-Cal Covered Services, including emergency mental health services, as described in 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

**Exhibit A, Attachment 10
COVERED SERVICES**

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 Contractor's mental health or substance use disorder Provider within Contractor's mental health and substance use disorder Provider Network.

- 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 for Members not otherwise excluded under this Contract.
 - i. This includes reimbursement for covered psychotherapeutic drugs prescribed by out-of- Network psychiatrists for Members.
 - ii. Contractor may require that covered prescriptions written by out-of- Network psychiatrists be filled by pharmacies in Contractor's Provider Network.

**Exhibit A, Attachment 10
COVERED SERVICES**

- iii. Reimbursement to pharmacies for those psychotherapeutic drugs that are listed in the Medi-Cal Pharmacy Provider Manual, County Organized Health Systems, Capitated/Noncapitated Drugs section, which lists excluded psychiatric drugs, shall be reimbursed through the Medi-Cal FFS program, whether these drugs are provided by a pharmacy contracting with Contractor or by an out-of-Network pharmacy Provider. To qualify for reimbursement under this provision, a pharmacy must be enrolled as a Medi-Cal Provider in the Medi-Cal FFS program.
 - h) 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 (services outside the scope of practice of Primary Care Providers) 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 Coordination of Care, Provision 7. 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.
- E. Tuberculosis (TB)
- TB screening, diagnosis, treatment and follow-up are covered under the

**Exhibit A, Attachment 10
COVERED SERVICES**

Contract. Contractor shall provide TB care and treatment in compliance with the guidelines recommended by American Thoracic Society and the Centers for Disease Control and Prevention.

Contractor shall coordinate with local health department in the provision of direct observed therapy as required in Exhibit A, Attachment 11, Case Management and Coordination of Care, Provision 17. Direct Observed Therapy (DOT) for Treatment of Tuberculosis (TB) and Attachment 12, Local Health Department Coordination.

F. Pharmaceutical Services and Provision of Prescribed Drugs

- 1) Contractor shall cover and ensure the provision of all prescribed drugs and Medically Necessary pharmaceutical services. Contractor shall provide pharmaceutical services and Prescription Drugs in accordance with all federal and State laws and regulations including, but not limited to, Title 22 CCR Sections 53214 and 53854, Title 16 CCR Sections 1707.1, 1707.2, and 1707.3, 42 CFR 438.3(s), and Sections 1927(d)(5) and 1927(k)(2) of the Social Security Act. Prior authorization requirements for pharmacy services and provision of prescribed drugs must be clearly described in the Member Services Guide and Contractor's provider manual.
- 2) Contractor shall arrange for pharmaceutical services to be available, at a minimum, during regular business hours. Contractor's drug utilization review (DUR) systems should be comparable to such programs administered by the State, and are subject to requirements outlined in 42 CFR 438.3(s), Section 1927(g) of the Social Security Act, and 42 CFR 456, subpart K.
- 3) Contractor shall ensure access to at least a 72-hour supply of a covered outpatient drug in an emergency situation. Contractor shall meet this requirement by doing all of the following:
 - a) Having written policies and procedures, including, if applicable, written policies and procedures of Contractor's Network hospitals' policies and procedures related to emergency medication dispensing, which describe the method(s) that are used to ensure that the emergency medication dispensing requirements are met, including, if applicable, specific language in Network hospital subcontracts. Written policies and procedures must describe how Contractor and/or Contractor's Network

**Exhibit A, Attachment 10
COVERED SERVICES**

hospitals will monitor compliance with the requirements. Compliance monitoring does not require verification of receipt of medications for each and every ER visit made by Members to an emergency room which does not result in hospitalization.

- b) Providing the Member, in all cases, access to at least a 72-hour supply of Medically Necessary drugs. This requirement can be met by providing a 72-hour supply of the drug to the Member, or provision of an initial dose of medication and a prescription for additional medication, which together cover the Member for the 72-hour period. Contractor's policies and procedures can describe other methods for ensuring compliance with the 72-hour requirement.
- c) Having a mechanism in place for informing Members of this requirement and of their right to submit a Grievance if they do not receive Medically Necessary medications in emergency situations.
- d) Having a procedure for investigating and resolving Grievances related to the failure of Contractor to provide Medically Necessary medications in emergency situations.
- e) Having policies and procedures and Grievance and Appeal logs available for inspection during any State audit or monitoring visit, upon request.

4) Continuity of Care

Contractor must maintain policies and procedures outlining continuity of care in compliance with the provisions of Welfare and Institutions Code 14185(b), and Health and Safety Code 1367.22. All newly enrolled Members shall be maintained on their current drug therapy, including non-formulary drugs without Prior Authorization until the Member is evaluated or re-evaluated by a Network Provider.

5) Formulary Requirements

Contractor shall post current formulary drug lists on Contractor's website in a machine readable file and format, and make a printed version available to Members upon request pursuant to 42 CFR 438.10(i). Contractor's drug formulary must meet the following

**Exhibit A, Attachment 10
COVERED SERVICES**

requirements:

- a) Contractor shall submit to DHCS a complete formulary for review and approval, prior to use. Contractor shall also submit an annual formulary to DHCS for review and approval. Contractor may use the formulary as published until DHCS notifies Contractor of approval or of required changes. In addition to the annual formulary submission, Contractor shall submit any changes to its formulary to DHCS as File and Use. DHCS may request an updated or current formulary at any time.
- b) Contractor's formulary shall be comparable to the Medi-Cal FFS Contract Drugs List (CDL), except for drugs carved out of this Contract. Comparable means that:
 - i. Every therapeutic category or class listed on the Medi-Cal FFS CDL shall be represented by at least one (1) drug on Contractor's formulary within six (6) months of its inclusion. Therapeutic category or class is defined by the American Hospital Formulary Service pharmacologic therapeutic classification system to include all tiers of United States Pharmacopeia.
 - ii. If Contractor places Prior Authorization requirements on all drugs within the same therapeutic category, and one (1) such drug is available on the Medi-Cal FFS CDL without treatment authorization request requirements, Contractor shall submit the following for all drugs of that same mechanism of action:
 - a. Clinical rationale for such an action.
 - b. Criteria used to decide on the Prior Authorization request and/or how the approval criteria for the formulary option(s) differs from the non-formulary options.
 - iii. A drug not listed on the formulary must be available by Prior Authorization if deemed Medically Necessary.
 - iv. All drugs listed on the Medi-Cal FFS list need not be included in Contractor's formulary.

**Exhibit A, Attachment 10
COVERED SERVICES**

- 6) The Contractor shall implement and maintain a process to ensure that its formulary is reviewed and updated, no less than quarterly, by Contractor's PTC. The PTC must include the following:
- a) A majority of members who are practicing Physicians and/or practicing pharmacists;
 - b) Contractor's Pharmacist as a voting member on the Committee;
 - c) At least one (1) practicing Physician and at least one (1) practicing pharmacist who are independent and free of conflict of interest from pharmaceutical manufacturers; and
 - d) At least one (1) practicing Physician and one (1) practicing pharmacist who are experts regarding care of elderly or disabled Members

This review and update of Contractor's formulary must consider all drugs approved by the FDA and/or added to Medi-Cal FFS CDL. Deletions to the formulary must be documented and justified.

- 7) Drug Utilization Review (DUR)

Contractor shall develop and implement effective DURs and treatment outcome processes as directed in APL 17-008 to assure that drug utilization is appropriate, Medically Necessary, and not likely to result in adverse events.

- a) Contractor's DURs must meet or exceed the requirements described in Section 1927(g) of the Social Security Act and 42 CFR 456, Subpart K.
- b) Contractor shall annually submit to DHCS a detailed report in a format specified by DHCS on their DUR Program activities.
- c) Contractor's process should also ensure that DURs are appropriately conducted and that pharmacy service and drug utilization Encounter Data are provided to DHCS on a monthly basis.

- 8) Reimbursement to pharmacies for those drugs for the treatment of

**Exhibit A, Attachment 10
COVERED SERVICES**

HIV/AIDS that are listed in the Medi-Cal Pharmacy Provider Manual, County Organized Health Systems, Capitated/Noncapitated Drugs section, which lists excluded HIV/AIDS drugs, shall be reimbursed through the Medi-Cal FFS program, whether these drugs are provided by a pharmacy contracting with Contractor or by an out-of-Network pharmacy Provider. To qualify for reimbursement under this provision, a pharmacy must be enrolled as a Medi-Cal Provider in the Medi-Cal FFS program.

- 9) Contractor shall not impose QTL or NQTL more stringently on mental health and substance use disorder drugs as compared to medical/surgical drugs prescriptions in accordance with 42 CFR 438.900 et. seq.

G. Other Standards

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

H. Transportation

Contractor shall cover transportation services as required in this Contract and directed in APL 17-010 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 required by Members to access Medi-Cal services, as provided for in Title 22 CCR Section 51323, subject to Contractor's Physician Certification Statement form being completed by the Member's Provider. Contractor shall refer and coordinate NEMT for 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

**Exhibit A, Attachment 10
COVERED SERVICES**

guidelines set forth in APL 17-010. Nothing in this Provision should be construed to prohibit the Contractor from developing policies and procedures which 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, substance use disorder, dental, and any other benefits delivered through Medi-Cal FFS.

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.

Exhibit A, Attachment 11
CASE MANAGEMENT AND COORDINATION OF CARE

1. Case Management Services

Contractor shall ensure contracted Providers provide basic Comprehensive Medical Case Management to each Member.

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

2. Comprehensive Case Management Including Coordination of Care Services

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

Contractor shall maintain procedures for monitoring the coordination of care provided to Members, including but not limited to all Medically Necessary services delivered both within and outside 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 shall 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 shall include, at a

**Exhibit A, Attachment 11
CASE MANAGEMENT AND COORDINATION OF CARE**

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
 - 4) With Member and PCP input, development of care plans specific to individual needs, and updating of these plans at least annually
 - 5) An assessment of transitional needs of Members into and out of Complex Case Management services.
- C. Contractor shall develop methods to identify Members who may benefit from complex case management services, using utilization data, the HIF/MET or other DHCS approved tool for this purpose, clinical data, and any other available data, as well as self and physician referrals. Complex case management services for SPD beneficiaries must include the concepts of Person-Centered Planning.
- D. Person-Centered Planning for SPD Beneficiaries
- 1) Upon the enrollment of a SPD beneficiary, Contractor shall provide, or ensure the provision of, Person-Centered Planning and treatment approaches that are collaborative and responsive to the SPD beneficiary's continuing health care needs.
 - 2) Person-Centered Planning shall include identifying each SPD beneficiary's preferences and choices regarding treatments and services, and abilities.
 - 3) Contractor shall allow or ensure the participation of the SPD beneficiary, and any family, friends, and professionals of their choosing, to participate fully in any discussion or decisions regarding treatments and services.
 - 4) Contractor shall ensure that SPD beneficiaries receive all necessary information regarding treatment and services so that they may make an informed choice.

Exhibit A, Attachment 11
CASE MANAGEMENT AND COORDINATION OF CARE

3. Discharge Planning and Care Coordination

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

- A. Documentation of pre-admission status, including living arrangements, physical and mental function, social support, Durable Medical Equipment (DME), and other services received
- 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, type of placement preferred by the SPD beneficiary/representative of the SPD beneficiary and hospital/institution, type of placement agreed to by the SPD beneficiary/representative of the SPD beneficiary, specific agency/home recommended by the hospital, specific agency/home agreed to by the SPD beneficiary/representative of the SPD beneficiary, and pre-discharge counseling recommended.
- D. Summary of the nature and outcome SPD beneficiary/representative of the SPD beneficiary involvement in the discharge planning process, anticipated problems in implementing post-discharge plans, and further action contemplated by the hospital/institution.

4. Targeted Case Management Services (TCM)

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

Exhibit A, Attachment 11
CASE MANAGEMENT AND COORDINATION OF CARE

Services under the Contract.

5. Disease Management Services

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

6. 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 7 through 18 below.

7. 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.
 - 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

Exhibit A, Attachment 11
CASE MANAGEMENT AND COORDINATION OF CARE

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.

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.

8. Alcohol and Substance Use Disorder Treatment Services

Alcohol and substance use disorder treatment services available under the 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 arrange for their referral to the county department responsible for substance use treatment, or other community resources when services are not available through the county, and to outpatient heroin detoxification Providers available through the Medi-Cal FFS program, for appropriate services. Contractor shall assist Members in locating available treatment service sites. To the extent that treatment slots are not available within the Contractor's Service Area, the Contractor shall pursue placement outside the area. Contractor shall continue to cover and ensure the provision of primary care and other services unrelated to the alcohol and substance use disorder treatment and coordinate services between the Primary Care Providers and the treatment programs.

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

9. Services for Children Under 21 Years of Age with Special Health Care Needs

Exhibit A, Attachment 11
CASE MANAGEMENT AND COORDINATION OF CARE

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

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

10. California Children's Services (CCS)

Upon diagnostic evidence that a Medi-Cal Member under 21 years of age may have a CCS-eligible condition, Contractor shall refer the Member to the local CCS office for determination of eligibility.

- A. Contractor shall develop and implement written policies and procedures for identifying and referring children with CCS-eligible conditions to the local CCS program. The policies and procedures shall include, but not be limited to those which:
 - 1) Ensure that Contractor's Providers perform appropriate baseline health assessments and diagnostic evaluations that provide sufficient clinical detail to establish, or raise a reasonable suspicion, that a Member has a CCS-eligible medical condition.
 - 2) Assure that Contracting Providers understand that CCS reimburses only CCS paneled Providers and CCS-approved hospitals within

**Exhibit A, Attachment 11
CASE MANAGEMENT AND COORDINATION OF CARE**

Contractor's Network; and only from the date of referral.

- 3) Enable initial referrals of Member's with CCS-eligible conditions to be made to the local CCS program by telephone, same-day mail or fax, if available. The initial referral shall be followed by submission of supporting medical documentation sufficient to allow for eligibility determination by the local CCS program.
 - 4) Ensure that Contractor continues to provide all Medically Necessary Covered Services for the Member's CCS-eligible condition until CCS eligibility is confirmed.
 - 5) Ensure that, once eligibility for the CCS program is established for a Member, Contractor shall continue to provide all Medically Necessary Covered Services that are unrelated to the CCS-eligible condition and shall monitor and ensure the coordination of services and joint case management between its Primary Care Providers, the CCS specialty Providers, and the local CCS program
 - 6) If the local CCS program does not approve eligibility, Contractor remains responsible for the provision of all Medically Necessary Covered Services to the Member. If the local CCS program denies authorization for any service, Contractor remains responsible for obtaining the service, if it is Medically Necessary, and paying for the service if it has been provided.
- B. Contractor shall execute a Memorandum of Understanding (MOU) with the local CCS program as stipulated in Exhibit A, Attachment 12, Provision 2, for the coordination of CCS services to Members.
- C. The CCS program authorizes Medi-Cal payments to Contractor Network physicians who currently are members of the CCS panel and to other Providers who provided CCS covered services to the Member during the CCS eligibility determination period who are determined to meet the CCS standards for paneling. Contractor shall inform Providers, except as noted above, that CCS reimburses only CCS paneled Providers. The Contractor shall submit information to the CCS program on all Providers who have provided services to a Member thought to have a CCS-eligible condition.

Authorization for payment shall be retroactive to the date the CCS program was informed about the Member through an initial referral by Contractor or a Contractor Network physician, via telephone, fax, or mail. In an emergency admission, Contractor or Contractor Network physician,

Exhibit A, Attachment 11
CASE MANAGEMENT AND COORDINATION OF CARE

shall be allowed until the next working day to inform the CCS program about the Member. Authorization shall be issued upon confirmation of panel status or determined to meet the CCS standards for paneling.

11. Services for Persons with Developmental Disabilities

- A. Contractor shall develop and implement procedures for the identification of Members with developmental disabilities.
- B. Contractor shall provide all screening, preventive, Medically Necessary, and therapeutic Covered Services to Members with developmental disabilities. Contractor shall refer Members with developmental disabilities to a Regional Center for the developmentally disabled for evaluation and for access to those non-medical services provided through the Regional Centers such as but not limited to, respite, out-of-home placement, and supportive living. Contractor shall monitor and coordinate all medical services and Medically Necessary Outpatient Mental Health Services with the Regional Center staff, including identification of all appropriate services, which need to be provided to the Member.
- C. Services provided under the Home and Community-Based Services (HCBS) waiver programs to persons with developmental disabilities are not covered under this Contract. Contractor shall implement and maintain systems to identify Members with developmental disabilities that may meet the requirements for participation in this waiver and refer these Members to the HCBS waiver program administered by the State Department of Developmental Services (DDS).

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

- D. 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.

12. Early Intervention Services

Contractor shall develop and implement systems to identify children under three (3) years of age who may be eligible to receive services from the Early Start Program and refer them to the local Early Start Program. These include children who have a developmental delay in either cognitive, communication, social,

Exhibit A, Attachment 11
CASE MANAGEMENT AND COORDINATION OF CARE

emotional, adaptive, physical, motor development, including vision and hearing, or a condition known to lead to developmental delay, or those in whom a significant developmental delay is suspected, or whose early health history places them at risk for delay. Contractor shall collaborate with the local Regional Center or local Early Start Program in determining the Medically Necessary diagnostic and preventive services and treatment plans for Members participating in the Early Start Program. Contractor shall provide case management and care coordination to the Member to ensure the provision of all Medically Necessary covered diagnostic, preventive and treatment services identified in the individual family service plan developed by the Early Start Program, with Primary Care Provider participation.

13. Local Education Agency (LEA) 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 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.

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

A. Coordination of Care

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

B. Cooperative Arrangements

Contractor shall enter into one (1) or a combination of the following arrangements with the local school district or school sites:

- 1) Subcontracts or other cooperative arrangements with school

**Exhibit A, Attachment 11
CASE MANAGEMENT AND COORDINATION OF CARE**

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 the Contractor agrees to provide or contribute staff or resources to support the provision of school linked CHDP services.
- 3) Referral protocols/guidelines between the Contractor and the school sites, which conduct CHDP screening only, to assure those Members who are identified at school sites as being in need of CHDP services receive those services from the Contractor within the required State and Federal time frames. This shall include strategies for the Contractor to follow-up and document that services are provided to the Member.
- 4) Any innovative approach that the Contractor may develop to assure access to CHDP services and coordination with and support for school based health care services.

C. Subcontracts

Contractor shall ensure that the Subcontracts with the local school districts or school sites meet the requirements of Exhibit A, Attachment 6, Provision 13, regarding Subcontracts, and address the following: the population covered, beginning and end dates of the agreement, services covered, practitioners covered, outreach, information dissemination, educational responsibilities, utilization review requirements, referral procedures, medical information flows, patient information confidentiality, quality assurance interface, data reporting requirements, and Grievance and Appeal procedures.

15. Waiver Programs

- A. Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) Home and Community Based Services Waiver Program
Services provided under the HIV/AIDS Home and Community Based Services Waiver are not covered under this Contract. Contractor shall maintain procedures for identifying Members who may be eligible for the

**Exhibit A, Attachment 11
CASE MANAGEMENT AND COORDINATION OF CARE**

HIV/AIDS Home and Community Based Services Waiver Program and shall facilitate referrals of these Members to the HIV/AIDS Home and Community Based Services Waiver Program. Contractor shall monitor and ensure the coordination of services with the Home and Community Based Waiver Program and continue to provide all Medically Necessary services to the member Medi-Cal beneficiaries enrolled in Medi-Cal managed care health plans who are subsequently diagnosed with HIV/AIDS, according to the definition most recently published in the Mortality and Morbidity Report from the Centers for Disease Control and Prevention, may participate in the HIV/AIDS Home and Community Based Services Waiver Program without having to disenroll from their Medi-Cal managed care plan. Members of Medi-Cal managed care plans must meet the eligibility requirements of the HIV/AIDS Home and Community Based Services Medi-Cal Waiver Program and enrollment is dependent on available space.

B. Home and Community Based Services (HCBS) Waiver Programs

DHCS administers a number of HCBS Waiver Programs authorized under Section 1915 (c) of the Social Security Act. Contractor shall have procedures in place to identify Members who may benefit from the HCBS Waiver Programs, and refer Members to the agency administering the waiver program. These waiver programs include, but are not limited to, the nursing facility/acute hospital waiver and all HCBS waivers. If the agency administering the waiver program concurs with Contractor's assessment of the Member and there is available placement in the waiver program, the Member will receive HCBS Waiver services while remaining enrolled with Contractor. Contractor shall continue comprehensive case management and shall continue to cover all Medically Necessary Covered Services to the Member. If the Member does not meet the criteria for the HCBS Waiver Program, or if placement is not available, Contractor shall continue to case manage and provide all Medically Necessary Covered Services to the Member.

16. Dental

Contractor shall cover and ensure that dental screenings/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/oral health assessment shall be performed as part of every periodic assessment, with annual dental referrals made with the eruption of the child's first tooth or at 12 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

Exhibit A, Attachment 11
CASE MANAGEMENT AND COORDINATION OF CARE

(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: contractually covered Prescription Drugs; laboratory services; and, pre-admission physical examinations required for admission to an out-patient surgical service center or an in-patient hospitalization required for a dental procedure, including facility fees and anesthesia services for both inpatient and outpatient services.

Effective for dates of service on or after June 1, 2006, HCPCS code D1203 (topical application of fluoride [prophylaxis not included], child) is a Medi-Cal benefit for children younger than six (6) years of age, up to three (3) times in a 12-month period. Physicians, nurses and medical personnel are legally permitted to apply fluoride varnish when the attending physician delegates the procedure and establishes protocol. (See MMCD All Plan Letter 07-008, issued April 18, 2007 and Medi-Cal Update - Billing and Policy, May 2006, Bulletin 382).

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

17. 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 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

Exhibit A, Attachment 11
CASE MANAGEMENT AND COORDINATION OF CARE

with mental illness, the elderly, persons with unmet housing needs, and persons with language and/or cultural barriers. If, in the opinion of the Contractor's Providers, a Member with one or more of these risk factors is at risk for noncompliance, the Member shall be referred to the LHD for DOT.

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

- B. Subject to Exhibit A, Attachment 12, Provision 4, Contractor shall execute a Memorandum of Understanding (MOU) with the LHD as stipulated in Exhibit A, Attachment 12, Provision 2, for the provision of DOT.

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

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

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

- B. Subject to Exhibit A, Attachment 12, Provision 4, Contractor shall execute a Memorandum of Understanding (MOU) with the WIC program as stipulated in Exhibit A, Attachment 12, Provision 2, for services provided to Members through the WIC program.

19. 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 that result in an immunization being provided. Reporting shall be in accordance with all applicable State and Federal laws.

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

**Exhibit A, Attachment 11
CASE MANAGEMENT AND COORDINATION OF CARE**

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 reimbursed by the Medi-Cal Fee-For-Service program.

Contractor shall identify individuals requiring ED drugs or ED therapies and arrange for their referral for appropriate services. Contractor shall assist Members in locating available treatment service sites. 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.

21. Long-Term Care

Effective February 1, 2010, Long-Term Care services are covered under this Contract. Contractor shall ensure that Members, other than Members requesting hospice services, in need of nursing Facility services are placed in a health care facility that provides the level of care most appropriate to the Member's medical needs. These health care facilities include Skilled Nursing Facilities, Subacute Facilities, Pediatric Subacute Facilities, and Intermediate Care Facilities. Contractor shall base decisions on the appropriate level of care on the definitions set forth in Title 22 CCR Sections 51118, 51120, 51120.5, 51121, 51124.5, and 51124.6 and the criteria for admission set forth in Title 22 CCR Sections 51335, 51335.5, 51335.6, and 51334 and related sections of the Manual of Criteria for Medi-Cal Authorization referenced in Title 22 CCR 51003(e).

Contractor shall provide all services at non-contracting facilities and shall not require Members residing in non-contracted facilities to relocate unless it is determined that relocation is medically necessary. Failure to comply with this provision shall entitle DHCS to recover damages pursuant to Exhibit E, Attachment 2, Provision 15. DHCS may recover damages pursuant to this provision no sooner than 30 days following Contractor's failure to comply. Hospice Services as defined in Title 22 CCR Section 51180 rendered in a Skilled Nursing Facility or Intermediate Care Facility are not long term care services consistent with Title 22 CCR Section 51544(h).

Exhibit A, Attachment 12
LOCAL HEALTH DEPARTMENT COORDINATION

1. Subcontracts

Contractor shall negotiate in good faith and execute a Subcontract or Memorandum of Understanding (MOU) for public health services listed in paragraphs A through D below with the local health department (LHD) in each county that is covered by this Contract. The Subcontract or MOU 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 LHD and the Contractor, including exchange of medical information as necessary. The Subcontract shall meet the requirements contained in Exhibit A, Attachment 6, Provision 13, regarding Subcontracts.

- A. Family Planning Services as specified in Exhibit A, Attachment 8, Provision 8.
- B. Sexually Transmitted Disease (STD) services for the disease episode, as specified in Exhibit A, Attachment 8, Provision 9, 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 10.
- D. Immunizations as specified in Exhibit A, Attachment 8, Provision 11.

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

2. Subcontracts or Memoranda of Understanding

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

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

Exhibit A, Attachment 12
LOCAL HEALTH DEPARTMENT COORDINATION

- 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. County department for alcohol and substance use disorder treatment services
- H. The county In-Home Support Services (IHSS) office and IHSS Public Authority.

3. County Mental Health Plan Coordination

- A. Contractor shall negotiate in good faith and execute a MOU with the county mental health plan in accordance with Welfare and Institutions Code Section 14715. The MOU shall specify, consistent with this Contract, the respective responsibilities of Contractor and the mental health plan in delivering and coordinating the care of Medically Necessary Covered Services and Specialty Mental Health Services to Members. The MOU shall address:
 - 1) Protocols and procedures for referrals between Contractor and the mental health plan.
 - 2) Protocols for the delivery of Specialty Mental Health Services, including the mental health plan's provision of clinical consultation to Contractor for Members being treated by Contractor for mental illness.
 - 3) Protocols for the delivery of mental health services within the Primary Care Provider's scope of practice.
 - 4) Protocols and procedures for the exchange of Medical Records information, including procedures for maintaining the confidentiality of Medical Records.
 - 5) Procedures for the delivery of Medically Necessary Covered Services to Members who require Specialty Mental Health Services, including:

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

- a) Pharmaceutical services and Prescription Drugs;
 - 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 mental health plan.
4. 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.
- 1) 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.
 - 2) 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. MOU Quarterly Reports

For purposes of this Attachment, to the extent Contractor does not execute an MOU within four (4) months after commencement of the Operations Period, upon approval of DHCS; 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 quarterly reports to DHCS documenting its continuing good faith efforts to execute an MOU and the justifications why such an MOU

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

has not been executed. Approval to submit quarterly reports shall not unreasonably be withheld.

**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 and Providers.

- 1) Contractor's written policies regarding Member rights shall include the following:
 - a) To be treated with respect, giving due consideration to the Member's right to privacy and the need to maintain confidentiality of the Member's medical information.
 - b) To be provided with information about the plan and its services, including Covered Services.
 - c) To be able to choose a Primary Care Provider within the Contractor's Network.
 - d) To participate in decision making regarding their own health care, including the right to refuse treatment.
 - e) To voice Grievances, either verbally or in writing, about the organization or the care received.
 - f) To receive oral interpretation services for their language. This includes communication access in alternative formats or through other methods that ensure communication, including assistive listening systems, sign language methods that ensure communication, including assistive listening systems, sign language interpreters, captioning, written communication, plain language or written translations and oral interpreters, including for those who are limited English proficient, or non-English speaking.
 - 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.

**Exhibit A, Attachment 13
MEMBER SERVICES**

- i) To request a State Medi-Cal state hearing, including information on the circumstances under which an expedited state hearing is possible.
 - j) To have access to, and where legally appropriate, receive copies of, amend or correct their Medical Record.
 - k) To access Minor Consent Services.
 - l) To receive written Member informing materials in an alternative format (including Braille, large size print, or audio format) upon request and in a timely fashion appropriate for the format being requested.
 - m) To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
 - n) To receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand.
 - o) Freedom to exercise these rights without adversely affecting how they are treated by Contractor, Providers, or the State.
 - p) To receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR §164.524 and 164.526.
 - q) 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 the Providers.

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.

**Exhibit A, Attachment 13
MEMBER SERVICES**

- 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 respecting advance directives in accordance with the requirements of 42 CFR 422.128 and 438.3(j), and Probate Code Sections 4673 to 4678 and Sections 4800 to 4806, and all applicable regulations.

2. Member Services Staff

- A. Contractor shall maintain the level of knowledgeable and trained staff sufficient to provide Covered Services to Members and all other services covered under this Contract.
- B. Contractor shall ensure Member Services staff are trained on all contractually required Member service functions including, policies, procedures, and scope of benefits of this Contract.
- 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.

3. Call Center Reports

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

4. Written Member Information

- A. Contractor shall provide all new Members with Member information and as stated in this Provision. Contractor shall provide each Member, or family unit, a Member Services Guide that constitutes a fair disclosure of the provisions of and the right to obtain available and accessible Covered Services including, but not limited to, health education.

**Exhibit A, Attachment 13
MEMBER SERVICES**

- B. Contractor shall provide the Member information no later than seven (7) calendar days following notification of Enrollment. Contractor shall distribute Member information annually to each Member or family unit. To provide Member information in any format other than as printed materials, including but not limited to in electronic format or upon request, Contractor must submit their process to DHCS for review and approval before implementing.
- 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 GNA and approved by DHCS. Member information shall ensure Members' understanding of Contractor's Covered Services, processes and the Member's ability to make informed health decisions.
- D. Member information shall include the Member Services Guide, 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.
 - 1) Member information shall be translated into the identified threshold and concentration languages discussed in Exhibit A, Attachment 9, Provision 13, Linguistic Services.
 - 2) Member information shall be provided in alternative formats (including Braille, large-size print font no smaller than 18-point, or audio 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.
 - 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) Member information in English shall include taglines and information on how to request Auxiliary Aids and services, including materials in alternative formats, in large print font no smaller than 18-point, and in all State threshold languages as required in this Provision. The taglines shall explain the availability of written Member information translated in that language or oral interpretation to understand the information provided, and the toll-free and TTY/TDD telephone number for Contractor's Member

**Exhibit A, Attachment 13
MEMBER SERVICES**

services.

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) Provider directories shall be compliant with 42 CFR 438.10(h) and Health and Safety Code 1367.27, and shall include the following information for PCPs, Specialists, hospitals, pharmacies, behavioral health Providers, MLTSS Providers as appropriate, and any other Providers contracted for Medi-Cal Covered Services:
 - a) The Provider or site's name and any group affiliation, NPI number, address, telephone number, 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;
 - d) The services and benefits available, including accessibility

**Exhibit A, Attachment 13
MEMBER SERVICES**

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; and
 - g) Identification of Providers or sites that are not available to all or new Members.
- F. DHCS shall provide Contractor with a template for the Member Services Guide prior to distribution to Members. Contractor shall submit a complete Member Services Guide to DHCS for review and approval prior to implementing. Contractor shall ensure that 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 provided in Title 28 CCR Sections 1300.51(d) and its Exhibit T (EOC) or U (Combined EOC/DF), if applicable. 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, and includes the following information:
- 1) The plan name, address, toll-free telephone number(s) for Member services and any other Contractor staff providing services directly to Members and Service Area covered by the health plan.
 - 2) A description of the full amount, duration, and scope of Medi-Cal Managed Care covered benefits and all available services including health education as prescribed in Exhibit A, Attachment 10, Provision 8, Paragraph A. 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 identify services to which the Contractor or Subcontractor has a moral objection to perform or support. Describe the arrangements for access to those services.

**Exhibit A, Attachment 13
MEMBER SERVICES**

- 3) Procedures for accessing Covered Services, which explain that Covered Services shall be obtained through Contractor's Providers unless otherwise allowed under this Contract, and the process for Members selecting and changing their PCP. Include any applicable Subcontractor arrangements that may restrict access.
- 4) A description of the Member identification card issued by the Contractor, if applicable, and an explanation as to its use in authorizing or assisting Members to obtain services.
- 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) 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. Include the use of 911 for obtaining emergency services.
- 9) The availability and procedures for obtaining after hours services (24-hour basis) and care, including the appropriate Provider locations and telephone numbers. This shall include an explanation of the Members' right to interpretive services, at no cost, to assist in receiving after-hours services.
- 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 Service Area.
- 11) Process for referral to Specialists in sufficient detail so Member can understand how the process works, including timeframes.
- 12) Procedures for obtaining any transportation services to Service Sites that are offered by Contractor or available through the Medi-

**Exhibit A, Attachment 13
MEMBER SERVICES**

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 with 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 the 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) Information on the Member's right to the Medi-Cal State Hearing process the method for obtaining a Hearing, and the rules that govern representation in a Hearing. Include information on the circumstances under which an expedited State Hearing is possible and information regarding assistance in completing the request pursuant to Title 22 CCR Section 53452, when a health care service requested by the Member or Provider has been denied, deferred or modified. Information on State Hearing shall also include information on the timelines which govern Member's right to a State Hearing, pursuant to Welfare and Institutions Code Section 10951 and the State Department of Social Services' Public Inquiry and Response Unit toll-free telephone number (1-800-952-5253) to request a State Hearing. Information shall be provided informing the Member that services previously authorized by the Contractor will continue while the State Hearing is being resolved.
- 15) Information on the availability of, and procedures for obtaining, services at Federally Qualified Health Centers and American Indian Health Service Programs.
- 16) Information on the Member's right to seek family planning services from any qualified Provider of family planning services under the

**Exhibit A, Attachment 13
MEMBER SERVICES**

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.

- 17) 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.
- 18) 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.
- 19) 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.
- 20) Information furnished on the availability of transitional Medi-Cal eligibility and how the Member may apply for this program.
- 21) 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, if applicable, the Department of Managed Health Care, Health Maintenance Organization (HMO) Consumer Service toll-free telephone number (1-800-400-0815).

**Exhibit A, Attachment 13
MEMBER SERVICES**

- 22) Information concerning the provision and availability of services covered under the California Children's Services program from Providers outside Contractor's Provider Network and how to access these services.
- 23) Information on how Minor Consent Services may be obtain through Contractor's Provider Network, an explanation of those services, and information on how they can also be obtained out of the Contractor's Provider Network.
- 24) An explanation on how to use Medi-Cal FFS when Medi-Cal Covered Services are excluded or limited under this Contract and how to obtain additional information.
- 25) An explanation of an American Indian Member's right not to be restricted in their access to American Indian Health Services Programs by Contractor, and to choose an American Indian Health Care Provider within Contractor's Network as a Primary Care Provider
- 26) A notice regarding the positive benefits of organ donations and how a Member can become an organ or tissue donor. Pursuant to Health and Safety Code Section 7158.2, this notice must be provided upon enrollment and annually thereafter in the evidence of coverage (Member Services Guide), health plan newsletter or any other direct communication with Members.
- 27) A statement as to whether the Contractor uses Provider financial bonuses or other incentives with its contracting Providers of health care services and that the Member may request additional information about these bonuses or incentives from the plan, the Member's Provider or the Provider's medical group or independent practice association.
- 28) Contractor's drug formulary information notice. Pursuant to 42 CFR 438.10(d)(6) and (i), the drug formulary information notice shall: (1) be in an easily understood and format; (2) include an explanation of what a formulary is, which medications are covered, both generic and name brand, what tier each medication is on, how the plan decides which Prescription Drugs are included or excluded from the formulary, and how often the formulary is updated; (3) indicate that the drug formulary is available on Contractor's website in a machine readable file, available in a hard copy, and provide the

**Exhibit A, Attachment 13
MEMBER SERVICES**

telephone number for requesting this information; and (4) indicate that the presence of a drug on the plan's formulary does not guarantee that a Member will be prescribed that drug by his or her prescribing Provider for a particular medical condition.

- 29) Policies and procedures regarding a Members' right to formulate advance directives. This information shall include the Member's right to be informed by the Contractor of State law regarding advance directives, and to receive information from the Contractor regarding any changes to that law. The information shall reflect changes in State law regarding advance directives as soon as possible, but no later than 90 calendar days after the effective date of change.
- 30) 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.
- 31) That Auxiliary Aids and services are available upon request and at no cost for Members with disabilities, and how to access these services. Include taglines in large-size print font no smaller than 18-point, on how to request Auxiliary Aids and Member information in alternative formats.
- 32) Information on how to report suspected fraud or abuse.
- 33) 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.

5. Member Notification of Changes in Access to Covered Services

- A. Contractor shall ensure Members are notified in writing of any significant changes in the availability or location of Covered Services, or any other significant changes in information listed in 42 CFR 438.10(g), at least 30 calendar days prior to the effective date of such changes. Whether such

**Exhibit A, Attachment 13
MEMBER SERVICES**

changes are significant for the purposes of this provision shall be determined solely by DHCS. In the event of a natural disaster or emergency, Contractor shall provide notice to Members as soon as possible, but no later than 14 calendar days. The notification to Members must be presented to and approved in writing by DHCS prior to its release.

- B. Pursuant to 42 CFR 438.10(f)(1), Contractor shall make a good faith effort to give written notice of termination of a contracted Provider within 15 calendar days after receipt or issuance of the termination notice to each Member who received his or her primary care from, or was seen on a regular basis by, the terminated Provider. This notification must also be presented to and approved in writing by DHCS prior to its release.

6. Primary Care Provider Selection

- A. Contractor shall implement and maintain DHCS approved procedures to ensure that each new Member has an appropriate and available Primary Care Physician (PCP). Contractor shall provide each new Member an opportunity to select a PCP within the first 30 calendar days of enrollment. Contractor may allow Members to select a clinic that provides Primary Care services. If the Contractor's Provider Network includes nurse practitioners, certified nurse midwives, or physician assistants, in accordance with Title 22 CCR Sections 51240 and 51241, the Member may select a nurse practitioner, certified nurse midwife, or physician assistant within 30 calendar days of enrollment to provide Primary Care services. 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. Contractor shall disclose to affected Members any reasons that their selection or change in PCP could not be made.
- C. Contractor shall ensure that Members with an established relationship with a Provider in Contractor's Network, who have expressed a desire to continue their patient/Provider relationship, are assigned to that Provider without disruption in their care.
- D. Contractor shall provide a mechanism for SPD beneficiaries to select a Specialist or clinic that meets DHCS subcontracting requirements as stated in Attachment 6 of this contract as a 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)

**Exhibit A, Attachment 13
MEMBER SERVICES**

- 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.

7. Primary Care Provider Assignment

- A. If the Member does not select a Primary Care Provider within 30 calendar days of the effective date of enrollment, Contractor shall assign that Member to a Primary Care Provider and notify the Member and the assigned Primary Care Provider no later than 45 calendar days after the Member's Enrollment. Contractor shall ensure that adverse selection does not occur during the assignment process of Members to Primary Care Providers. If, at any time, a Member notifies the Contractor of a Primary Care Provider or Subcontracting Health Plan choice, such choice shall override the Member assignment to a Primary Care Provider or Subcontracting Health Plan.
- B. If 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 Provider assignment, including a Specialist or clinic 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 selected or been assigned to the Provider within 15 calendar days from when selection or assignment is completed by the Member or the Contractor, respectively.
- D. Contractor shall maintain procedures that include contracting Traditional and Safety-Net Providers in the assignment process for Members who do not choose a Primary Care Provider.
- E. Submit policies and procedures for Member assignment to a Primary Care Physician. Include the use of FFS utilization data and other data in linking

**Exhibit A, Attachment 13
MEMBER SERVICES**

an APD beneficiary to a PCP.

- F. 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.
- G. Contractor shall provide any Member utilization data received from DHCS to the Primary Care Provider or Subcontractor to which a Member has been assigned 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.

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

- A. Contractor shall notify Members of a decision to deny, defer, or modify requests for Prior Authorization in accordance with 42 CFR 438.210(c) by providing a NOA to Members and/or their authorized representative, regarding any denial, deferral or modification of a request for approval to provide a health care service. This notification must be provided as specified in 42 CFR 438.404, Title 22 CCR Sections 51014.1, 51014.2, 53894, and Health and Safety Code Section 1367.01.
- B. Contractor shall ensure that at least 10 days of advanced notice, with exceptions as noted in the contract, is given to a Member when a NOA results in a termination, suspension, reduction of services, or reduction of previously authorized covered services. The Contractor shall shorten the advanced notice to five (5) days if fraud probable recipient fraud has been verified. When Contractor receives a request for continues services less than 10 days in advance of the completion of previously approved services, Contractor shall provide the advanced notice within five (5) days of receipt of request for continuation of services.

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

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

**Exhibit A, Attachment 13
MEMBER 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 per Social Security Act 1919 (E)(7);
 - 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 Member's urgent medical needs, or Member has not resided in the nursing facility for a minimum of 30 days.
- C. Contractor shall provide expedited advanced notice to a Member when Contractor or Primary Care Physician indicates that the standard timeframe could seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum function. Contractor shall ensure an expedited authorization decision and provide an expedited notice as the Member's health condition requires and no later than 72 hours after receipt of the request for services. Upon approval from DHCS, Contractor may extend the 72 hours 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 authorized representative on a standardized form, approved by DHCS, informing the Member of all the following:
- 1) The Member's right to, method of obtaining, and time limit for requesting a State Hearing to contest the denial, deferral, or modification action and the decision the Contractor has made, the reason(s) for the action and the specific regulation(s) or plan authorization procedures supporting the action.
 - 2) The Member's right to represent himself/herself at the State

**Exhibit A, Attachment 13
MEMBER SERVICES**

Hearing or to be represented by legal counsel, friend or other spokesperson.

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

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

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

**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 (except Subdivision 1300.68(c)(g) and (h)), 1300.68.01(except Subdivision 1300.68.01(b) and (c)), Title 22 CCR Section 53858, Exhibit A, Attachment 13, Provision 4, paragraph F.13, 42 CFR 438.402-424. Contractor shall follow Grievance and Appeal requirements, and use all notice templates included in APL 17-006. Contractor shall ensure that the following requirements are met through its Grievance and Appeal system:

- 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 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, within 30 calendar days from the date Contractor receives the Grievance or request for an Appeal. Contractor shall notify the Member of the resolution in a written Member notice.
- C. For Members accessing the Grievance and Appeal system, ensure that reasonable assistance is given in completing forms and other procedural steps, which includes but is not limited to, 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 and 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, and 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;
 - 2) A Grievance regarding denial of an expedited resolution of an Appeal; and
 - 3) Any Grievance or Appeal involving clinical issues.
- E. Take into account all comments, documents, records, and other information submitted by the Member or their representative, without regard to whether such information was submitted or considered in the initial action.

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

- 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. Contactor 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 of this Contract.
- H. Provide oral notice of the resolution of an expedited review within 72 hours.
- I. Provide its Grievance and Appeal system requirements to Subcontractors at the time that they enter into a Subcontract.
- J. Compile the systematic aggregation and analysis of Grievance and Appeal data and use for Quality Improvement.

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, 406, and 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 an 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.

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

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

- 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 sub-contracting entity delegated the 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). Contractor shall also apply the information requirements for Grievance logs to the inclusion of Appeals.
- B. Contractor shall submit a quarterly Grievance and Appeal report for Medi-Cal Members only as set forth in Title 28 CCR Section 1300.68(f) or in a format approved by DHCS, with additional information required by DHCS per 42 CFR 438.416. The report should include an explanation for each Grievance and Appeal that was not resolved within 30 calendar days of receipt of the Grievance or request for an Appeal.
 - 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, untimely assignments to a Primary Care Provider, issues related to cultural and linguistic sensitivity, difficulty with accessing Specialists, and Grievances related to Contractor's denial of requests for out-of-Network requests.
 - 2) For the Medi-Cal category of the report, Contractor shall provide the following additional information:
 - a) The total number of Grievances and Appeals received
 - b) The average time it took to resolve Grievances or Appeals, which includes providing written notification to the Member.
 - c) The date Contractor received the Grievance or Appeal;
 - d) A general description of the reason for the Grievance or Appeal;
 - e) The date(s) of Contractor's review of the Grievance or Appeal, or if applicable, a review meeting;
 - f) The resolution and date of resolution, at each level of the Grievance or Appeal;
 - g) The name of the Member for whom review of a Grievance or Appeal was requested;

Exhibit A, Attachment 14
MEMBER GRIEVANCE AND APPEAL SYSTEM

- h) A listing of the zip code, ethnicity, gender, and primary language of the Member who filed the Grievance or Appeal.
- C. Contractor shall submit reports resulting from its quarterly review and analysis of all recorded Grievances as required by Title 22 CCR Section 53858(e)(4).
- D. Contractor shall submit the quarterly Grievance and Appeal reports for the following quarters: April – June, July – September, October – December, January – March. The reports are due 30 calendar days from the date of the end of the reporting quarter.

4. Notice of Action (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 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 the timeframes stated in Exhibit A, Attachment 13, Provision 8, Paragraph B.
 - 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 failure to authorize Covered Services in a timely manner, send on the date that the timeframe expires.
 - 5) For the decision to extend the time frame to authorize a Covered Service and provide information on filing a Grievance if the Member disagrees, send within 14 calendar days following receipt of the request.
 - 6) For an expedited service authorization decision, send within

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

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 Exhibit A, Attachment 13, Provision 4, and must include all of the following:
- 1) The action that Contractor or its Subcontractor has taken or intends to take;
 - 2) The reason for the action, including notification to the Member of the right to be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and any other information relevant to the action, including the Medical Necessity criteria, and any processes, strategies, or evidentiary standards used;
 - 3) The Member's 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) The Member's right to request a State Fair Hearing after requesting an Appeal and receiving notice that Contractor is upholding its action, or after Contractor fails to send a resolution notice or extension in response to the Appeal within 30 calendar days;
 - 5) Procedures for exercising the Member's rights to request an Appeal or a State Fair Hearing;
 - 6) Circumstances under which an expedited Appeal is available and how to request it;
 - 7) The member's right to have Covered Services continue pending the resolution of the Contractor-level Appeal; and
 - 8) How to request a continuation of Covered Services.
- C. Once a NOA is sent:
- 1) Members have 60 calendar days from the date on the NOA to request an Appeal of Contractor's action.
 - 2) Knox-Keene licensed health plans for Medi-Cal members. Members may request a review of Contractor's action, called an Independent Medical Review (IMR), from the Department of

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

Managed Health Care (DMHC).

- D. Member must be notified 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 Fair Hearing, the State must reach its decision within three (3) working days of receipt of the expedited State Fair Hearing request. Contractor shall also comply with all other requirements as outlined in APL 03-009, APL 17-006.

5. Appeal Process

Contractor shall have in place a process as described below to resolve Member requests for Appeals. Contractor may have only one level of Appeal for Members.

- 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 without regard to whether the Member submitted a written request for an Appeal.
- B. If Contractor fails to send a Member resolution notice within 30 calendar days, the Member is deemed to have exhausted Contractor's internal Appeal process and can request a State Fair Hearing. A Member resolution notice, at a minimum, must include the result and date of the Appeal resolution. For decisions not wholly in the Member's favor, Contractor, at a minimum, must include:
- 1) Member's right to request a State Hearing;
 - 2) How to request a State Hearing;
 - 3) Right to continue to receive benefits pending a State Hearing;
 - 4) How to request the continuation of benefits, and requirements to file a continuation within ten (10) calendar days of when the NOA was sent, or before the intended effective date of the proposed action; and
- C. Contractor may extend the timeframe to resolve an Appeal by up to 14

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

calendar days if the Member requests an extension or Contractor shows that there is a need for additional information and how 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 an 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 a Member Grievance for the delay.
 - 3) Resolve as expeditiously as the Member's health condition requires and no later than the date the extension expires.
- D. 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 State Hearing Appeal is pending and/or Contractor reverses a decision to deny, limit, or delay services.
- E. Contractor must pay for disputed services if the Member received the disputed services while the Appeal was pending.
- F. Contractor shall continue providing Covered Services while the Appeal is pending if the 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.
- G) If Contractor, at the Member's request, continues or reinstates the provision of Covered Services while an Appeal or State Fair Hearing is pending, those services must continue until:

Exhibit A, Attachment 14
MEMBER GRIEVANCE AND APPEAL SYSTEM

- 1) The Member withdraws their request for an Appeal or a State Fair Hearing;
 - 2) The Member fails to request a State Fair Hearing and continuation of Covered Services within 10 calendar days of when the NOA was sent; or
 - 3) The State Fair Hearing decision is adverse to the Member.
- H. 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 upon request, 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 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 or a Provider or 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 and no additional Member follow-up is required. Contractor must ensure that punitive action is not taken 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.
- D. 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

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

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 give the Member a written notice of both the reason for the extension and the right to file a Grievance if the Member disagrees with the decision. Contractor shall resolve the Appeal as expeditiously as the Member's health condition requires and no later than the date the extension expires.

- E. Contractor must make a reasonable effort to provide oral notice of expedited Contractor-level Appeal decision.
- F. 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 Fair Hearings

A. State Fair 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 Fair Hearing:
 - a) After receiving a notice of resolution stating that Contractor's action has been upheld, and the request is made within 120 calendar days from the date on the notice of resolution; or
 - b) If they have exhausted the Appeals process due to Contractor failing to adhere to Appeal notice and timing requirements as stated in this Contract.
- 2) During the State Fair Hearing process, Contractor must authorize or provide the disputed services promptly, and as expeditiously as the Member's health condition requires, but no later than 72 hours from the date Contractor receives notice reversing the determination, if the services are not furnished while the Hearing is pending and Contractor reverses a decision to deny, limit, or delay services.
- 3) Contractor must pay for disputed services if the Member received the disputed services while the Hearing was pending.

B. Expedited State Fair Hearings

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

- 1) Within two (2) Working days of being notified by DHCS or the California Department of Social Services (CDSS 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 CDSS 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 notice of action (NOA), plus any pertinent Appeal resolution notice. If the NOA or Appeal resolution notices are not in English, fully translated copies shall be transmitted to CDSS along with copies of the original NOA and Appeal resolution notice.
- 2) One 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.

8. Parties to an Appeal or a State Fair Hearing

The parties to an Appeal or a State Fair Hearing include Contractor as well as the Member and his or her representative or the representative of a deceased Member's estate.

**Exhibit A, Attachment 15
MARKETING**

1. Training and Certification of Marketing Representatives

Contractor shall develop a training and certification program for Marketing Representatives, as described in this Exhibit A, Attachment 15, and ensure that all staff performing Marketing activities or distributing Marketing material are appropriately certified. **This Attachment is not applicable if Contractor does not perform marketing activities pursuant to their federally approved waiver.**

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

**Exhibit A, Attachment 15
MARKETING**

- 6) An explanation of the requirements of confidentiality of any information obtained from Medi-Cal beneficiaries including information regarding eligibility under any public welfare or social services program.
- 7) An explanation of how Marketing Representatives will be supervised and monitored to assure compliance with regulations.
- 8) An explanation of acceptable communication and sales techniques. This shall include an explanation of prohibited Marketing Representative activities and conduct.
- 9) 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 without written approval of its Marketing plan, or changes to its Marketing plan, from DHCS. In cases where the Contractor wishes to conduct an activity not included in the marketing plan, Contractor shall submit a request to include the activity and obtain written, prior approval from DHCS. Contractor must submit the written request within 30 calendar days prior to the Marketing event, unless DHCS agrees to a shorter period.
- B. All Marketing materials, and changes in Marketing materials, including but not limited to, all printed materials, illustrated materials, videotaped and media scripts, shall be approved in writing by DHCS prior to distribution
- C. Contractor's training and certification program and changes in the training and certification program shall be approved in writing by DHCS prior to implementation.

3. Marketing Plan

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

The organizational chart shall include the Marketing director's name, address, telephone and facsimile number and key staff positions.

The description shall explain how the Contractor's internal Marketing department operates, identifying key staff positions, roles and responsibilities, and, reporting relationships including, if applicable, how the Contractor's commercial Marketing staff and functions interface with its Medi-Cal Marketing staff and functions.

c) Marketing Locations

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

d) Marketing Activities

All Marketing methods and Marketing activities Contractor expects to use, or participate in, shall be described.

**Exhibit A, Attachment 15
MARKETING**

Contractor shall comply with the guidelines described, as applicable, in Title 22 CCR Sections 53880 and 53881, Welfare and Institutions Code Sections 10850(b), 14407.1, 14408, 14409, 14410, and 14411, and as follows:

- i. Contractor shall not engage in door-to-door, telephone, e-mail, texting, cold call, telephone, or other Marketing for the purpose of enrolling Potential Enrollees.
- ii. Contractor shall obtain DHCS approval to perform in-home Marketing presentations and shall provide strict accountability, including documentation of the prospective Member's request for an in-home Marketing presentation or a documented telephone log entry showing the request was made.
- iii. Contractor shall not conduct Marketing presentations at primary care sites.
- 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.

**Exhibit A, Attachment 15
MARKETING**

f) Marketing Distribution Methods

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

g) Monitoring and Reporting Activities

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

h) Miscellaneous

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

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

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
ENROLLMENT AND DISENROLLMENTS**

1. Enrollment

Each Eligible Beneficiary residing within the Service Area of Contractor may be enrolled at any time during the term of this Contract. Each Eligible Beneficiary shall be accepted by Contractor and enrolled as a Member with Contractor in the order in which he/she applies, 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.

2. Assignment of Members

If Member fails to timely choose a Primary Care Physician or a Subcontracting Health Plan, the Contractor shall notify the Member in writing of the Primary Care Physician or Subcontracting Health Plan with whom the Member will be assigned. If, at any time, a Member notifies the Contractor of a Primary Care Physician or Subcontracting Health Plan choice, such choice shall override the Member Assignment to a Primary Care Physician or Subcontracting Health Plan.

3. 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, including retroactive Eligible Beneficiaries.

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.

4. Continuance of Membership

A Member's Enrollment shall continue unless this Contract expires, is terminated, or the Member is disenrolled under the conditions described in Provision 5. below.

5. Disenrollment

A. Disenrollment of a Member is mandatory when:

- 1) The Member's eligibility for Medi-Cal is ended, including the death of the Member.

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

- 2) There is a change of a Member's county code outside Contractor's Service Area.

**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 Form)	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
Attachment 4 QUALITY IMPROVEMENT SYSTEM (QIS)		
4. Quality Improvement Committee	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 (EAS) 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		
10. Provider Network Report	Provider Network Report	Quarterly
11. Plan Subcontractors	Plan Subcontractors Report	Quarterly
Contract Section	Requirement	Frequency
Attachment 9 ACCESS AND AVAILABILITY		
12. Cultural and Linguistic Services Program C. Group Needs Assessment (GNA)	Group Needs Assessment Summary Report	Every 5 years

**Exhibit A, Attachment 17
REPORTING REQUIREMENTS**

Attachment 10 SCOPE OF SERVICES		
5. Services for Members under Twenty-One (21) Years of Age B. Preventive Services for Members under Age 21 5)	Confidential Screening/Billing Report Form, PM 160-PHP	Monthly
5. Services for Members under Twenty-One (21) Years of Age F. Behavioral Health Treatment Services	BHT Reporting Template	First Six Months: Monthly After Six Months: Quarterly
8. Services for All Members F. Pharmaceutical Services and Provision of Prescribed Drugs 5)	Report of Changes to the Formulary	Annually
8. Services for All Members F. Pharmaceutical Services and Provision of Prescribed Drugs 7)	Report of DUR Program Activities	Annually
Attachment 12 LOCAL HEALTH DEPARTMENT COORDINATION		
4. MOU Quarterly Reports	Local Health Department - MOU's County Mental Health - MOU's (If deemed necessary)	Quarterly
Attachment 13 MEMBER SERVICES		
3. Call Center Reports	Call Center Reports	Quarterly
4. Written Member Information B.	Member Services Guide	Annually
Attachment 14 MEMBER GRIEVANCE AND APPEAL SYSTEM		
3. Grievance and Appeal Log and Quarterly Grievance and Appeal Report B.	Grievance and Appeal Report	Quarterly
Attachment 15 MARKETING		
3. Marketing Plan A.	Marketing Plan	Annually
Attachment 16 ENROLLMENTS AND DISENROLLMENTS		
1. Enrollment Program (PL 11-009)	Provider Directory	Semi-Annually
Attachment 19 COMMUNITY BASED ADULT SERVICES (CBAS)		

**Exhibit A, Attachment 17
REPORTING REQUIREMENTS**

6. Required Reports for the CBAS Program A.	Provision of ECM Report	Quarterly
6. Required Reports for the CBAS Program B.	CBAS Enrollment Report	Quarterly
6. Required Reports for the CBAS Program C.	Addition to Call Center Report	Quarterly
6. Required Reports for the CBAS Program D.	Addition to Grievance Report and Appeal	Quarterly
Attachment 20 MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS		
3. Provider Network Reports A.	Addition to the Provider Network Report	Quarterly
3. Provider Network Reports B.	Outpatient Mental Health Services 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 Call Center Reports	Quarterly
10. Required Reports for Managed Long Term Services and Supports E.	Addition to Member Grievances and Appeals Report	Monthly
10. Required Reports for Managed Long Term Services and Supports F.	PCP Assignment	Monthly
Exhibit B – BUDGET DETAIL AND PAYMENT PROVISIONS		
13. Payment of AIDS Capitation Rates for Members with AIDS B.	AIDS Capitation Rates Invoice	Monthly
Exhibit E - ADDITIONAL PROVISIONS		
Attachment 2 PROGRAM TERMS AND CONDITIONS		
34. Treatment of Recoveries C. Recovery of Overpayment	Recovery of Overpayment Report	Annually

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

If Contractor has not begun Operations, all of the items required by this Attachment must be submitted to DHCS by Contractor and approved to DHCS prior to the beginning of Operations. If Contractor has already begun Operations but has not, for any reason, previously provided any of the items to DHCS, each item must also be provided to DHCS. Unless specified otherwise herein, Contractor shall have a continuing obligation to update the deliverables required by this Attachment whenever the information in the deliverables changes in any material respect, or upon revision requested by DHCS. This obligation extends for the duration of this Contract; updates should be submitted to DHCS, for review and approval, within 30 days of any material change. The approval process for updates shall be in accordance with Exhibit E, Attachment 3, Provision 5. Approval Process for Submitted Material During Operations, except that if DHCS does not complete its review of any submitted material within 60 calendar days of receipt of the submitted material it shall be deemed currently approved; however, DHCS reserves the right to subsequently inform Contractor that any submitted material that has been deemed approved is no longer approved. Unless expressly requested by DHCS, Contractor is not required to submit any of the items in this Attachment if the item contains current information and is currently on file with DHCS. All submitted financial information must adhere to Generally Accepted Accounting Principles (GAAP), unless otherwise noted.

If Contractor has not begun Operations, or is expanding its Service Area or scope of benefits, within 15 calendar days from the effective date of this Contract, Contractor shall submit a Workplan that describes in detail how and when the Contractor will submit and complete the deliverables to DHCS in accordance with the Implementation Plan and Deliverables in this Attachment. The Contractor's Workplan(s) will include a timetable to accomplish the activities to assure timely start-up of operations and contingency plans in the event of implementation delays.

The Contractor's Workplan(s) will identify all of the deliverables, milestones, and timeframes to achieve an orderly sequence of events that will lead to compliance with all contract requirements. DHCS will review and approve each of the Workplan(s). However, Contractor shall not delay the submission of deliverables required in the Workplan(s) while waiting for DHCS approval of previously submitted deliverables required by the Workplan(s). Contractor will continue to submit deliverables based on the milestones and timeframes set forth in the approved DHCS Workplan(s). In the event the Contractor fails to submit all required deliverables in accordance with the milestones and timeframes in the approved DHCS Workplan(s), DHCS may impose sanctions or any other remedy available under this Contract, or applicable law.

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

Contractor shall submit:

1. Organization and Administration of Plan

Submit the following consistent with the requirements of Exhibit A, Attachment 1. Contractor may request approval from DHCS to file an alternative document or documents in lieu of the documents required in this provision. Such request(s) shall be in writing and shall specify the reason(s) the alternative document or documents sufficiently meet DHCS needs with respect to the information requested. Approvals of such requests shall not be unreasonably withheld and denials of such requests shall be accompanied by an explanation for the denial in writing. DHCS shall respond to such requests within ten (10) calendar days of receipt of the request or the request shall be deemed to be approved.

- A. Submit documentation of employees (current and former State employees) who may present a conflict of interest.
- B. Submit a complete organizational chart.
- C. Submit the following Knox-Keene license exhibits and forms found in Title 28 CCR Section 1300.51 et seq reflecting current operation status:
 - 1) Type of Organization: Submit the following applicable exhibits and forms as appropriate for its type of organization and administration of the health plan.
 - a) Corporation: Exhibits F-1-a-I through F-1-a-iii and Corporation Information Form, Form HP 1300.51-A.
 - b) Partnership: Exhibits F-1-b-I and F-1-b-ii and Partnership Information Form, Form HP 1300.51-B.
 - c) Sole Proprietorship: Exhibit F-1-c and Sole Proprietorship Information Form, Form HP 1300.51-C.
 - d) Other Organization: Exhibits F-1-d and F-1-d-ii, and Information Form for other than Corporations, Partnerships, and Sole Proprietorships, Form HP 1300.51-D
 - e) Public Agency: Exhibits F-1-e-I through F-1-e-iii.

Title 28 CCR 1300.51(d)F1a - e
 - 2) Exhibit F-1-f: Individual Information Sheet (Form HP 1300.51.1) for

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

each person named in response to item 1) above.

Title 28 CCR Section 1300.51(d)F1f

- 3) Exhibits F-2-a and F-2-b: contracts with Affiliated person, Principal Creditors and Providers of Administrative Services.

Title 28 CCR Section 1300.51(d)F2

- 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.

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

Title 28 CCR Section 1300.51(d)N1&2

2. Financial Information

Submit the following consistent with the requirements of Exhibit A, Attachment 2. Contractor may request approval from DHCS to file an alternative document or documents in lieu of the documents required in this provision. Such request(s) shall be in writing and shall specify the reason(s) the alternative document or documents sufficiently meet DHCS needs with respect to the information requested. Approvals of such requests shall not be unreasonably withheld and denials of such requests shall be accompanied by an explanation for the denial in writing. DHCS shall respond to such requests within ten (10) calendar days of receipt of the request or the request shall be deemed to be approved.

- 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

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

- 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 proposal. 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
- 3) Exhibit II-3

Title 28 CCR Section 1300.51(d)(II)

G. Describe systems for ensuring that Subcontractors, who are at risk for providing services to Medi-Cal Members, as well as any obligations or requirements delegated pursuant to a Subcontract, have the administrative and financial capacity to meet its contractual obligations.

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

Title 28 CCR Section 1300.70(b)(2)(H)1. 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. Submit policies and procedures for a system to evaluate and monitor the financial viability of all subcontracting entities.

3. Management Information System (MIS)

Submit the following consistent with the requirements of Exhibit A, Attachment 3.

- A. Submit a completed Baseline Assessment Form upon request by DHCS.
- B. When procuring a new MIS or modifying a current system, Contractor shall provide a detailed implementation plan that includes:
 - 1) Outline of the tasks required;
 - 2) The major milestones;
 - 3) The responsible party for all related tasks;
 - 4) A full description of the acquisition of software and hardware, including the schedule for implementation;
 - 5) Full documentation of support for software and hardware by the manufacturer or other contracted party;
 - 6) System test flows through a documented process that has specific control points where evaluation data can be utilized to correct any deviations from expected results;
 - 7) Documentation of system changes related to the Health Insurance Portability and Accountability Act of 1996 requirements.
 - 8) An Encounter Data test produced using real or proxy data processed by a new or modified MIS must be submitted 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.

Exhibit A, Attachment 18
IMPLEMENTATION PLAN AND DELIVERABLES

- 9) Contractor's MIS will be reviewed against the model MIS Guidelines. Submit a detailed description of the proposed and/or existing MIS as it relates to the following subsystems:
 - a) Financial
 - b) Member/Eligibility
 - c) Provider
 - d) Encounter/Claims
 - e) Quality Management/Utilization
- 10) Submit a sample and description of the following reports generated by the MIS:
 - a) Member roster
 - b) Provider Listing
 - c) Capitation Payments
 - d) Cost and Utilization
 - e) System edits/audits
 - f) Claims payment status/processing
 - g) Quality Assurance
 - h) Utilization
 - i) Monitoring of Complaints
- 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 policies and procedures for the submission of complete, accurate, timely, and reasonable Encounter Data.
- E. Submit the data security, backup, or other data disaster processes used in

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

the event of a MIS failure.

4. Quality Improvement System (QIS)

Submit the following consistent with the requirements of Exhibit A, Attachment 4.

- A. Submit a written description of the QIS, including:
 - 1) A flow chart and/or organization chart identifying all components of the QIS and who is involved and responsible for each activity.
 - 2) A description of the responsibility of the Governing Body in the QIS.
 - 3) A description of the QI Committee, including Membership, activities, roles and responsibilities.
 - 4) A description of how Providers will be kept informed of the written QIS, its activities and outcomes.
 - 5) A description of how Plan reports any disease or condition to public health authorities.
- B. Submit policies and procedures related to the delegation of the QIS activities.
- C. Submit boilerplate Subcontract language showing accountability of delegated QIS functions and responsibilities.
- D. Submit policies and procedures to address how the Contractor will meet the requirements of:
 - 1) External Accountability Set (EAS) Performance Measures
 - 2) Performance Improvement Projects
 - 3) Consumer Satisfaction Survey
- E. 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) and Primary Care Provider site reviews.
- F. Submit a list of sites to be reviewed prior to initiating plan operation, existing or in expanded areas.

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

- G. Submit the aggregate results of pre-operational, existing or in expanded areas, site review to DHCS at least six (6) weeks prior to plan operation. The aggregate results shall include all data elements defined by DHCS.
- H. Submit policies and procedures for credentialing and re-credentialing.

5. Utilization Management (UM)

Submit the following consistent with the requirements of Exhibit A, Attachment 5.

- A. Submit written description of UM program that describes appropriate processes to be used to review and approve the provision of medical, 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. Include:
 - 1) Procedures for Prior Authorization, concurrent review, and retrospective review.
 - 2) A list of services requiring Prior Authorization and the utilization review criteria.
 - 3) Procedures for the utilization review appeals process for Providers and Members.
 - 4) Procedures that specify timeframes for medical authorization.
 - 5) Procedures to detect both under- and over-utilization of health care services.
- B. Submit policies and procedures showing how delegated activities will be regularly evaluated for compliance with Contract requirements and, that any issues identified through the UM program are appropriately resolved, and that UM activities are properly documented and reported.

6. Provider Network

Submit the following consistent with the requirements of Exhibit A, Attachment 6.

- A. Submit a complete Provider Network that is adequate to provide required Covered Services for Members in the Service Area.

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

- B. Submit policies and procedures describing how Contractor will monitor Provider to patient ratios to ensure they are within specified standards
- C. Submit policies and procedures regarding physician supervision of non-physician medical practitioners.
- D. Submit policies and procedures for providing emergency services.
- E. Submit a complete list of Specialists by type within the Contractor's Network.
- F. Submit policies and procedures for how Contractor will meet federal requirements for access and reimbursement to Network and/or out-of-Network Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), and Freestanding Birthing Center (FBC) services consistent with Exhibit A, Attachment 6, Provision 6. Federally Qualified Health Center Services.
- G. Submit a GeoAccess report (or similar) showing that the proposed Provider Network meets the appropriate time and distance standards set forth in Exhibit A, Attachment 6, Provision 7. Time and Distance Standard.
- H. Submit a policy regarding the availability of a health plan or contracting physician 24-hours a day, 7-days a week, and procedures for communicating with emergency room personnel.
- I. Submit a report containing the names of all subcontracting Provider groups (see Exhibit A, Attachment 6, Provision 11. Plan Subcontractors).
- J. Submit an analysis demonstrating the ability of the Contractor's Provider Network to meet the ethnic, cultural, and linguistic needs of the Contractor's Members.
- K. Submit all boilerplate Subcontracts, signature page of all Subcontracts, and reimbursement rates. DHCS will maintain the confidentiality of the rates to the extent provided by State law.
- L. Submit policies and procedures for ensuring Subcontractors fully comply with all terms and conditions of this Contract.
- M. Submit policies and procedures that establish Traditional and Safety-Net Provider participation standards.

7. Provider Relations

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

Submit the following consistent with the requirements of Exhibit A, Attachment 7.

- A. Submit policies and procedures for Provider grievances.
- B. Submit protocols for payment and communication with non-contracting Providers.
- C. Submit copy of Contractor's Provider Manual.
- D. Submit policies and procedures for ensuring Out-of-Network Providers receive Contractor's clinical protocols and evidence-based practice guidelines.

8. Provider Compensation Arrangements

Submit the following consistent with the requirements of Exhibit A, Attachment 8.

- A. Submit description of any physician incentive plans.
- B. Submit policies and procedures for processing and payment of claims.
- C. Submit excerpt from Contractor's provider manual that describes the prohibition of a claim or demand for services provided under the Medi-Cal managed care contract, to any Medi-Cal member.
- D. Submit FQHC, RHC, and American Indian Health Service Programs Subcontracts.
- E. Submit policies and procedures for the reimbursement of non-contracting Certified Nurse Midwives (CNM) and Certified Nurse Practitioners (CNP).
- F. Submit schedule of per diem rates and/or Fee-for-Service rates for each of the following Provider types:
 - 1) Primary Care Providers
 - 2) Medical Groups and Independent Practice Associations
 - 3) Specialists
 - 4) Hospitals
 - 5) Pharmacies

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

- G. Submit policies and procedures for reporting Provider-Preventable Conditions.

9. Access and Availability

Submit the following consistent with the requirements of Exhibit A, Attachment 9.

- A. Submit policies and procedures that include standards for:
 - 1) Appointment scheduling
 - 2) Routine specialty referral
 - 3) First prenatal visit
 - 4) Waiting times
 - 5) Urgent care
 - 6) After-hours calls
 - 7) Specialty services
- B. Submit policies and procedures for the timely referral and coordination of Covered Services to which the Contractor or Subcontractor has objections to perform or otherwise support, consistent with Exhibit A, Attachment 9, Provision 4.
- C. Submit policies and procedures for standing referrals.
- D. Submit policies and procedures regarding 24-hours a day access without Prior Authorization, follow-up and coordination of emergency care services.
- E. Submit policies and procedures regarding access to Nurse Midwives and Nurse Practitioners.
- F. Submit policies and procedures regarding access for disabled Members pursuant to the Americans with Disabilities Act of 1990.
- G. Submit policies and procedures regarding Contractor and Subcontractor compliance with the Civil Rights Act of 1964.

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

- H. Submit a written description of the Cultural and Linguistic Services Program, required by Exhibit A, Attachment 9, Provision 12. Include policies and procedures for providing cultural competency, sensitivity or diversity training for staff, providers, and subcontractors, as well as policies and procedures for monitoring and evaluation of the Cultural and Linguistic Services Program.
- I. Submit policies and procedures for the provision of 24-hours a day interpreter services at all Provider sites.
- J. Submit policies and procedures for providing medically necessary services through Out-of-Network Providers, including allowing access for the completion of Covered Services by an Out-of-Network Provider or terminated Provider.
- K. Submit policies and procedures to ensure access for up to 12 months for SPD beneficiaries who have an ongoing relationship with a Provider.
- L. 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.

10. Scope of Services

Submit the following consistent with the requirements of Exhibit A, Attachment 10.

- A. Submit policies and procedures for providing:
 - 1) The Initial Health Assessment (IHA)
 - 2) The Individual Health Education Behavioral Assessment (IHEBA).
 - 3) Contractor shall submit policies and procedures for ensuring that all appropriate staff receive training on a continuing basis regarding clinical protocols, evidenced-based practice guidelines, and DHCS developed cultural awareness and sensitivity instruction for SPD

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

beneficiaries.

- 4) Submit policies and procedures for administering the Health Risk Stratification and Assessment to SPD beneficiaries, including other DHCS approved tools for this purpose, and other health information used for risk stratification.
 - 5) Submit Contractor's risk stratification mechanism or algorithm designed for the purpose of identifying newly enrolled SPD beneficiaries as high or low risk.
 - 6) 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.
 - 7) Contractor shall submit policies and procedures for ensuring providers receive training on a continuing basis regarding clinical protocols, evidenced-based practice guidelines, and DHCS developed cultural awareness and sensitivity instruction for SPD beneficiaries.
 - 8) Contractor shall submit policies and procedures for administering and ensuring the provision of the IHA to SPD beneficiaries. The IHA shall include the IHEBA.
- B. Submit policies and procedures, including standards, for the provision of the following services for Members under age 21 years of age:
- 1) Preventive services
 - 2) Immunizations
 - 3) Blood Lead screens
 - 4) Screening for Chlamydia
 - 5) EPSDT services
- C. Submit policies and procedures for the provision of preventive services, including immunizations for Members 21 years of age and older
- D. Submit policies and procedures for the provision of services to pregnant Members, including:

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

- 1) Prenatal care
 - 2) Use of American College of Obstetricians and Gynecologists (ACOG) standards and guidelines
 - 3) Comprehensive risk assessment for all pregnant Members.
 - 4) Referral to Specialists
- E. Submit a list of appropriate hospitals available within the Provider Network that provide necessary high-risk pregnancy services.
- F. Provide a detailed description of the health education system including policies and procedures which address:
- 1) Administration and Oversight of the Health Education System;
 - 2) Delivery of Health Education Programs, Services and Resources;
 - 3) Evaluation and Monitoring of the Health Education System.
 - 4) Submit a timeline and work plan for the development and performance of a Group Needs Assessment that shall be completed within 12 months of the startup of operations for the entire Service Area.
- G. Submit a list and schedule of all health education programs (including classes) that are provided either directly or via subcontract by the plan.
- H. Submit policies and procedures for the provision of:
- 1) Hospice care
 - 2) Vision care – Lenses
 - 3) Mental health services
 - 4) Tuberculosis services
 - 5) NEMT/NMT
- I. Submit standards and guidelines for the provision of pharmaceutical services and prescribed drugs, including providing at least a 72-hour supply of a covered outpatient drug when prescribed in an emergency.

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

- J. Submit a complete drug formulary.
- K. Submit a process for review of drug formulary.
- L. Submit policies and procedures for conducting a Drug Utilization Review (DUR).
- M. Submit policies and procedures for the distribution and use of the Health Information Form (HIF) data submitted through the Member Evaluation Tool (MET), or other DHCS approved tool for this purpose.
- N. Submit policies and procedures for the UM of covered pharmaceutical services, demonstrating compliance with mental health parity requirements set forth in 42 CFR 438.900 et. seq.

11. Case Management and Coordination of Care

Submit the following consistent with the requirements of Exhibit A, Attachment 11.

- A. Submit procedures for monitoring the coordination of care provided to Members. Include procedures used to monitor the provision of Basic Care Management.
- B. Submit procedures for administering and monitoring the provision of Complex Case Management to Members. Include procedures to identify members who may benefit from complex case management services
- C. Submit policies and procedures for ensuring the provision of Person-Centered Planning for SPD beneficiaries as part of case management and coordination of care.
- D. Submit policies and procedures for ensuring the provision of Discharge Planning.

For the remaining items (E. – Y.), If these items are included in Contractor’s provider manual, submitted under item 7.D, provide a table/list of where the items can be found in the provider manual. Otherwise, submit each item as listed below and include a description of how they are communicated to Network Providers.

- E. Submit policies and procedures for coordinating care of Members who are receiving services from a targeted case management Provider.

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

- F. Submit policies and procedures for the referral of Members under the age of 21 years that require case management services.
- G. Submit policies and procedures for a disease management program. Include policies and procedures for identification and referral of Members eligible to participate in the disease management program.
- H. Submit policies and procedures for referral and coordination of care for Members in need of Specialty Mental Health Services from the county Medi-Cal mental health plan or other community resources.
- I. Submit policies and procedures for resolving disputes between Contractor and the county mental health plan.
- J. 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 the Contractor's Service Area.
- K. Submit a detailed description of Contractor's program for Children with Special Health Care Needs (CSHCN).
- L. Submit policies and procedures for identifying and referring children to the local CCS program.
- M. Submit policies and procedures for the identification, referral and coordination of care for Members with developmental disabilities in need of non-medical services from the local Regional Center and the Department of Developmental Services (DDS)-administered Home and Community Based Waiver program.
- N. Submit policies and procedures for the identification, referral and coordination of care for Members at risk of developmental delay and eligible to receive services from the local Early Start program.
- O. Submit policies and procedures for case management coordination of care of Local Education Agency (LEA) services, including primary care physician involvement in the development of the Member's Individual Education Plan or Individual Family Service Plan.
- P. Submit policies and procedures for case management coordination of care of Members who receive services through local school districts or school sites.

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

- Q. Submit a description of the Subcontracts or other cooperative arrangements Contractor has with the local school districts, including the Subcontracts or written protocols/guidelines, if applicable.
- R. Submit policies and procedures describing the cooperative arrangement that Contractor has regarding care for children in Foster Care.
- S. Submit policies and procedures for identification and referral of Members eligible to participate in the Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome Home and Community Based Waiver Program.
- T. Submit policies and procedures for the provision of dental screening and covered medical services related to dental services.
- U. Submit policies and procedures for coordination of care and case management of Members with the local health department (LHD)/Tuberculosis (TB) Control Officer.
- V. Submit policies and procedures for the assessment and referral of Members with active TB and at risk of non-compliance with TB drug therapy to the LHD.
- W. Procedures to identify and refer eligible Members for Women, Infants, and Children Program (WIC) services.
- X. Submit policies and procedures for assisting Members eligible for the following services:
 - 1) Major organ transplants
 - 2) Federal Medicaid Waiver programs
- Y. Submit policies and procedures for assessment of transitional needs of Members into and out of Complex Case Management services:
 - 1) At the request of PCP or Member
 - 2) Achievement of targeted outcomes
 - 3) Change of healthcare setting
 - 4) Loss or change in benefits

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

- 5) Member non- compliance

12. Local Health Department Coordination

Submit the following consistent with the requirements of Exhibit A, Attachment 12.

- A. Submit executed Subcontracts or documentation substantiating Contractor's efforts to enter into Subcontracts with LHD for the following public health services:
 - 1) Family planning services
 - 2) Sexually Transmitted Disease (STD) services
 - 3) Human Immunodeficiency Virus (HIV) testing and counseling
 - 4) Immunizations
- B. Submit executed Subcontracts, Memoranda of Understanding, or documentation substantiating Contractor's efforts to negotiate an agreement with the following programs or agencies:
 - 1) California Children Services (CCS)
 - 2) Maternal and Child Health
 - 3) Child Health and Disability Prevention Program (CHDP)
 - 4) Tuberculosis Direct Observed Therapy
 - 5) Women, Infants, and Children Supplemental Nutrition Program (WIC)
 - 6) Regional Centers for services for persons with developmental disabilities.
 - 7) 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

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

Submit the following consistent with the requirements of Exhibit A, Attachment 13.

- A. Submit policies and procedures that address Member's rights and responsibilities. Include method for communicating them to both Members and Providers.
- B. Submit policies and procedures for addressing advance directives.
- C. Submit policies and procedures for the training of Member Services staff.
- D. Submit policies and procedures regarding the development content and distribution of information to Members. Address appropriate reading level and translation of materials.
- E. Submit final draft of Member Identification Card and Member Services Guide (Evidence of Coverage and Disclosure Form).
- F. 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.
- G. 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.
- H. Submit policies and procedures for notifying Primary Care Provider that a Member has selected or been assigned to the Provider within 10 days.
- I. 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.
- J. Submit policies and procedures for notifying Members for denial, deferral, or modification of requests for Prior Authorization
- K. Submit policies and procedures for providing communication access to SPD beneficiaries in alternative formats or through other methods that 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

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

limited English-proficient (LEP), or non-English speaking.

14. Member Grievance and Appeal System

Submit the following consistent with the requirements of Exhibit A, Attachment 14.

- A. Submit policies and procedures relating to Contractor's Member Grievance and Appeal system.
- B. Submit format for Quarterly Grievance and Appeal Log and Report.
- C. Submit policies and procedures relating to Contractor's Member NOA, when services have been denied, deferred, or modified.
- D. Submit policies and procedures relating to Contractor's Member Appeals process. Include Contractor's responsibilities in expedited Appeals and State Fair Hearings.
- E. 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.

15. Marketing

Submit the following consistent with the requirements of Exhibit A, Attachment 15.

- A. Submit Contractor's marketing plan, including training program and certification of marketing representatives.
- B. Submit a copy of boilerplate request form used to obtain DHCS approval of participation in a marketing event.

16. Enrollments

Submit the following consistent with the requirements of Exhibit A, Attachment 16

- A. Submit policies and procedures for how Contractor will assign Members to Primary Care Physicians or a Subcontracting Health Plan.

17. Confidentiality of Information

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

Submit the following consistent with the requirements of Exhibit E, Attachment 2, Provision 22.

- A. Submit policies addressing Member's rights to confidentiality of medical information. Include procedures for release of medical information.

18. 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.

19. 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 policies and procedures for providing Enhanced Case Management services.
- D. Submit policies and procedures for the initial assessment and reassessment of Members for eligibility to receive CBAS.
- 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.

20. Mental Health and Substance Use Disorder Benefits

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

- A. Submit policies and procedures for adding licensed mental health Providers to Contractor's Network, including which services shall be offered by licensed mental health Providers.

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

- B. Submit policies and procedures for ensuring timely access to Outpatient Mental Health Services.
- C. Submit any Subcontract boilerplate developed for a county mental health plan.
- D. Submit policies and procedures for subcontracting 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 Outpatient Mental Health Services.
- 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 Outpatient Mental Health Services.
- 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 prevent problematic substance use
 - 2) Referral, without requiring Prior Authorization to AMSC services for Members whose PCPs do not offer AMSC; and
 - 3) Referral, without requiring Prior Authorization, of Members to substance use disorder treatment when there is a need beyond AMSC.

21. Managed Long-Term Services and Supports

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

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

- A. 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.
- B. Submit policies and procedures for the provision of LTC and the Multipurpose Senior Services Program (MSSP) as Covered Services.
- C. Submit policies and procedures for the provision of continuity of care through continued access to 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.
- D. Submit policies and procedures for the risk stratification process conducted for Full Benefit Dual Eligible, Partial Dual Eligible, and Medi-Cal Only Members.
- E. 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.
- F. 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.

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 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. Contractor shall ensure that every ADHC Provider within their service area that has been approved by the California Department of Aging as a CBAS Provider as of July 1, 2012, is included in their Network, to the extent that the CBAS Provider remains licensed, certified, operating, and is willing to enter into a subcontract with Contractor on mutually agreeable terms and meets the Contractor's credentialing and quality standards.
- B. If Contractor determines that additional CBAS Providers are necessary to meet the needs of its Members, Contractor may extend a contract to any CBAS Provider certified by the California Department of Aging after July 1, 2012. Contractor shall consider a Member's relationship with previous CBAS Providers when ensuring access to CBAS. Contractor shall not be required to include CBAS Providers that were certified by the California Department of Aging after July 1, 2012 in their Provider Network.
- C. If Contractor determines that Member needs for CBAS exceeds Contractor's CBAS Provider capacity, Contractor shall arrange for access to unbundled services in accordance with the California Bridge to Reform Waiver 11-W-00193/9, Special Terms and Conditions, Paragraph 91.m.
- D. Contractor shall include CBAS Provider information within the quarterly Provider Network Report submission in Exhibit A, Attachment 6, Provision 10.
- E. 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.
- F. Contractor shall notify DHCS when unable to contract with a certified CBAS Provider or upon termination of a CBAS Provider contract:
 - 1) If Contractor and a CBAS Provider cannot agree on mutually agreeable terms, the Contractor must notify DHCS within five (5) working days of the Contractor's decision to exclude the CBAS Provider from its Provider Network. DHCS will attempt to resolve the contracting issue when appropriate.

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

- 2) Contractor shall provide DHCS with notice of its termination of a CBAS Provider contract at least 60 days prior to the contract termination effective date.

2. Covered Services

In addition to Exhibit A, Attachment 10, Provision 1, Covered Services and in accordance with the California Bridge to Reform Waiver 11-W-00193/9, Special Terms and Conditions, Paragraph 91.f. and g., Contractor agrees to provide CBAS from July 1, 2012 through August 31, 2014, and shall:

- A. Arrange for the provision of CBAS to Members determined eligible to receive CBAS in accordance with Provision 5, Assessment and Reassessment of CBAS.
- B. Consider a Member's relationship with a previous Provider of services similar to CBAS when referring a Member to a CBAS Provider.
- C. Seek to offer CBAS as a bundled service through a certified CBAS Provider.
- D. Arrange for the provision of unbundled services, based on the assessed needs of the Member eligible for CBAS if a certified CBAS Provider is not available or not contracted, or there is insufficient CBAS Provider capacity in the area. In accordance with the California Bridge to Reform Waiver 11-W-00193/9, Special Terms and Conditions, Paragraph 91.m., unbundled services are limited to:
 - 1) Services authorized by Contractor
 - a) Professional Nursing Services
 - b) Nutrition
 - c) Physical Therapy
 - d) Occupational Therapy
 - e) Speech and Language Pathology Services
 - f) NEMT only between the Member's home and the CBAS unbundled service Provider

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

- 2) Services coordinated by Contractor. In addition to the requirements for unbundled CBAS services contained in this provision, and in accordance with Exhibit A, Attachment 11, Provision 6, Out-of-Network Case Management and Coordination of Care, Contractor shall coordinate care for unbundled CBAS services, based on the assessed needs of the member eligible for CBAS, that are not covered services, including:
 - a) Personal Care Services
 - b) Social Services
 - c) Physical and Occupational Maintenance Therapy
 - d) Meals
 - e) Mental Health Services
- E. If a Member has been determined CBAS eligible by DHCS and is receiving care from a CBAS Provider pending assessment by the Contractor, Contractor shall continue the provision of CBAS until an assessment has been completed in accordance with Provision 5, Assessment and Reassessment of Community Based Adult Services.
- F. Contractor shall not impede or delay Member access to Medicare Providers or services through its provision of CBAS or ECM.

3. Enhanced Case Management

From April 1, 2012, through August 31, 2014, ECM services shall be offered to Members who received ADHC services from Medi-Cal at any time between July 1, 2011 through February 29, 2012 and who are determined to be ineligible for CBAS. A Member determined to be eligible for ECM may at a later date be determined eligible for CBAS. If the Member receives CBAS, the Member will no longer receive ECM. If at a later time the Member no longer receives CBAS, the Member will then be eligible to receive ECM.

A Member eligible for ECM who receives CBAS at some time between April 1, 2012 and August 31, 2014, is eligible to receive ECM for any time period during which they do not receive the CBAS benefit. A Member shall not receive ECM and CBAS concurrently.

The Contractor shall provide ECM benefits in accordance with the California Bridge to Reform Waiver 11-W-00193/9, Special Terms and Conditions,

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

Paragraph 92.b. For the purposes of this provision ECM services are defined as:

- A. Basic Case Management Services are provided by the primary care provider, in collaboration with the Contractor, and shall include:
 - 1) Initial Health Assessment (IHA)
 - 2) Initial Health Education Behavioral Assessment (IHEBA)
 - 3) Identification of appropriate providers and facilities (such as medical, rehabilitation, and support services) to meet Member care needs
 - 4) Direct communication between the provider and Member/family
 - 5) Member and family education, including healthy lifestyle changes when warranted
 - 6) Coordination of carved out and linked services, and referral to appropriate community resources and other agencies.
- B. Complex Case Management Services are provided by the Contractor, in collaboration with the primary care provider, and shall include, at a minimum:
 - 1) Basic Case Management Services
 - 2) Management of acute or chronic illness, including emotional and social support issues by a multidisciplinary case management team
 - 3) Intense coordination of resources to ensure member regains optimal health or improved functionality
 - 4) With Member and PCP input, development of care plans specific to individual needs, and updating of these plans at least annually
- C. Person-Centered Planning
 - 1) Upon the enrollment of a Member eligible for ECM, Contractor shall provide, or ensure the provision of, Person-Centered Planning and treatment approaches that are collaborative and responsive to the Member's continuing health care needs.
 - 2) Person-Centered Planning shall include identifying Member's

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

preferences and choices regarding treatments and services, and abilities.

- 3) Contractor shall allow or ensure the participation of the Member, and any family, friends, and professionals of the Member's choosing, to participate fully in any discussion or decisions regarding the Member's treatments and services.
- 4) Contractor shall ensure that the Member receives all necessary information regarding treatment and services to make an informed choice.

4. Provision of ECM Services

- A. ECM services shall be provided in addition to the requirements in Exhibit A, Attachment 11, Provision 1, Case Management Services.
- B. For Members who had received ADHC services between July 1, 2011 and February 29, 2012 but are ineligible to receive CBAS, Contractor shall continue to approve the provision of CBAS until ECM service referrals are made, a care plan has been developed, and Contractor has referred the Member to services as advised in the care plan
- C. Contractor may contract with a CBAS Provider or other appropriate entity for the provision of ECM services to eligible Members.
- D. Contractor shall attempt to contact Members who had received ADHC services between July 1, 2011 and February 29, 2012 but are ineligible to receive CBAS a minimum of three (3) separate times to initiate ECM. If Member refuses to engage in ECM or Contractor is unable to make contact with the Member after three (3) separate attempts, Contractor's obligation to provide outreach efforts for ECM services to that Member will have been met. Contractor shall provide ECM services in accordance with the requirements in Exhibit A, Attachment 19, Provision 3, Enhanced Case Management if the Member requests it after outreach effort obligations have been met.

5. Assessment and Reassessment for CBAS

Contractor shall ensure that the initial assessment and reassessment procedures for Members requesting CBAS, or who have previously been deemed eligible to receive CBAS, meet the following minimum requirements:

- A. Contractor shall ensure appropriate staff responsible for conducting,

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

managing, and/or training for an initial assessment or reassessment of Members for CBAS shall receive training from DHCS on using the approved assessment tool.

- B. Contractor shall conduct the CBAS eligibility determination of a Member requesting CBAS using the assessment tool approved by DHCS. CBAS eligibility determinations shall include a face-to-face review of the Member. Contractor shall include a Registered Nurse with level of care experience and a social worker on the assessment team, either as an employee or as a sub-contractor.
- C. Contractor shall develop and implement an expedited assessment process to determine CBAS eligibility when informed of Members in a hospital or skilled nursing facility whose discharge plan includes CBAS, or who are at high risk of, admission to a skilled nursing facility.
- D. Contractor shall reassess and redetermine the Member's eligibility for CBAS at least every six (6) months after the initial assessment, or whenever a change in circumstances occurs that may require a change in the Member's CBAS benefit
- E. If Member is already receiving CBAS and requests that services remain at the same level or be increased due to a change in level of need, Contractor may conduct the reassessment using only the Member's IPC, including any supporting documentation supplied by the CBAS Provider.
- F. 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 experience and utilizing the assessment tool approved by DHCS.
- G. Contractor shall notify Members in writing of the CBAS assessment determination in accordance with the timeframes identified in Exhibit A, Attachment 13, Provision 8, Denials, Deferrals, or Modifications of Prior Authorization Requests. 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.
- H. Contractor shall require that CBAS Providers complete a CBAS Discharge Plan of Care for any Members who have been determined to no longer need CBAS.

6. Required Reports for the CBAS Program

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

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

- A. Contractor shall report to DHCS the number of Members who received ADHC services from July 1, 2011 to February 29, 2012 and have been determined ineligible to receive CBAS and have received ECM services within the specified reporting time period.
- B. Contractor shall report to DHCS how many Members have been assessed for CBAS, the total number of Members currently being provided with CBAS, both as a bundled and unbundled service.
- C. In addition to the requirements set forth in Exhibit A, Attachment 13, Provision 3, Call Center Reports, Contractor shall also include a review of any complaints surrounding the provision of CBAS benefits.
- D. 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.

7. Payment Rates to CBAS Providers

- A. All CBAS Providers, whether contracted or not, will be reimbursed for providing the CBAS benefit between July 1, 2012 and August 31, 2014 at the rate described below, minus ten percent, except in exempted Medical Service Study Areas which will receive the rates below:
 - 1) Comprehensive multidisciplinary evaluation - \$80.08 per evaluation.
 - 2) Community Based Adult Services, adult - \$76.27 per day.

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

- 3) Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter - \$64.83 per encounter.
- B. Contractor shall not be required to pay more than the Medi-Cal fee schedule as detailed in the California Bridge to Reform Waiver 11-W-00193/9, Special Terms and Conditions, Paragraph 91.m. for unbundled CBAS.

Exhibit A, Attachment 20
MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS

1. Outpatient Mental Health Services Providers

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

- A. Contractor shall increase the number of Outpatient Mental Health Services Providers within its Network as necessary to accommodate enrollment growth. Contractor may subcontract with any mental health care Provider within their scope of practice.
- B. The number of Outpatient Mental Health Services Providers available shall be sufficient to meet referral and appointment access standards for routine care and shall meet the Timely Access Regulation per Healthy and Safety Code, Section 1367.03, Rule 1300.67.2.2, in accordance with the requirements set forth in Exhibit A, Attachment 9, Access and Availability, Provision 3, Access Requirements.
 - 1) Contractor may subcontract with a county mental health plan to ensure access to Outpatient Mental Health Services. A subcontracted Network shall be deemed adequate upon submission and approval of Contractor's subcontract boilerplate 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 Outpatient Mental Health Services 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 Outpatient Mental Health Services 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 Outpatient Mental Health Service that is not available within the Provider

Exhibit A, Attachment 20
MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS

Network, Contractor shall ensure access to Out-of-Network Provider and Telehealth mental health Providers 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 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 Outpatient Mental Health Services.

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 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.

Exhibit A, Attachment 20
MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS

- 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 10. Provider Network Report, the Provider Network report shall identify the number of licensed mental health care Providers. The report shall include:
 - 1) Mental health care Provider deletions and additions.
 - 2) The percentage of Providers who deliver services through the Telehealth method, if applicable.
- B. Contractor shall submit monthly reports on Outpatient Mental Health Services 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. Outpatient Mental Health Care Services

- A. Outpatient Mental Health Services 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 Outpatient Mental Health Services 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 Outpatient Mental Health Services 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;

Exhibit A, Attachment 20
MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS

- 4) Psychiatric consultation;
 - 5) Outpatient laboratory, supplies, and supplements; and
 - 6) AMSC for substance use conditions.
- 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:
- 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 disorder.
- G. If a Member becomes eligible for Specialty Mental Health Services during the course of receiving medically necessary Outpatient Mental Health Services, Contractor shall continue the provision of non-duplicative, Medically Necessary Outpatient Mental Health Services.

5. Alcohol and Substance Use Disorder Treatment Services

Exhibit A, Attachment 20
MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS

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.

**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. Quality Improvement System

In addition to Exhibit A, Attachment 4, Quality Improvement System, Provision 12. Credentialing and Recredentialing, Contractor is not responsible for credentialing Multipurpose Senior Services Program (MSSP) Providers. Credentialing MSSP Providers is the responsibility of the California Department of Aging (CDA).

3. Utilization Management

Notwithstanding Exhibit A, Attachment 5, Utilization Management, Provision 2, Prior authorizations and Review Procedures, Contractor shall not authorize MSSP services. Contractor shall refer Members who are potentially eligible for MSSP to MSSP Providers for authorization. Contractor shall collaborate and coordinate MSSP care management services with MSSP Providers.

4. Provider Network

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

- A. Contractor shall ensure that every contracted Long Term Care (LTC) and MSSP site within the Service Area approved by the California Department of Public Health (CDPH) and CDA 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 subcontract 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 exceeds

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

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 subcontract termination requirements in Exhibit A, Attachment 6, Provision 14. Subcontracts, 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 a LTC Provider contract:
- 1) If Contractor and a 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.
 - 2) Contractor shall provide DHCS with notice of its termination of a contract with a 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 a LTC Provider during the 60 days between notifying DHCS and the contract termination effective date.
- E. Any subcontract that Contractor enters into with a CDA qualified MSSP site, for either the provision of health care service or to perform an administrative function, shall be submitted to DHCS for prior approval at least 60 calendar days prior to the effective date of the contract. DHCS shall acknowledge in writing the receipt of any subcontract sent to DHCS by Contractor for approval within five (5) working days of receipt. These subcontracts shall not be effective until written approval is provided by DHCS and CDA or by operation of law where DHCS has acknowledged receipt of the proposed subcontract, and has neither approved nor rejected the proposed subcontract within 60 calendar days of receipt.
- 1) Contractor shall also submit a subcontract for MSSP to DHCS for

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

approval even if the subcontractor has been previously approved by DHCS and CDA for another program.

- 2) Any new or updated subcontract that makes a material change to the subcontract must be re-submitted to DHCS. Previous subcontract approval shall be valid only until such time as the new or amended subcontract is approved by DHCS and CDA.
- F. Subcontract amendments shall be submitted to DHCS for prior approval at least 30 calendar days before the effective date of any proposed changes governing compensation, services, or term. Proposed changes which are neither approved nor rejected by DHCS and CDA shall become effective by operation of law 30 calendar days after DHCS has acknowledged receipt or upon the date specified in the subcontract amendment, whichever is later.

5. 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.

6. Provider Compensation Arrangements

In addition to Exhibit A, Attachment 8, Provider Compensation Arrangements, Contractor also agrees to the following:

- A. Skilled Nursing Facilities and Nursing Facilities (SNF/NF) claims are to be paid in accordance with Welfare and Institutions Code Sections 14182.16 and 14186.3.
- B. MSSP invoices submitted by subcontracted MSSP sites for MSSP services are to be paid in a timely manner upon verification of the accuracy and validity of the services invoiced therein, and in accordance with Contractor's subcontract with the MSSP site.
- C. For MSSP services, Contractor must follow the process under statute, W&I Code Section 14186.3 (b)(7)(A).

7. Covered Services

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

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. MSSP are Covered Services under this Contract. In addition to Exhibit A, Attachment 10, Scope of Services, Contractor shall also cover Medically Necessary MSSP in accordance with the eligibility determination as performed by the the appropriate MSSP site, and ensure the provision of these services in accordance with the requirements set forth below in Provision 8. Coordination of Care.

- A. Contractor shall not be required to determine Member eligibility to receive MSSP.
- B. Contractor shall refer MSSP eligibility determination to the MSSP site for approval.
- C. Contractor shall refer to the MSSP site for confirmation of Member eligibility and to verify if the Member has been enrolled in MSSP.
- D. Contractor shall continue to cover MSSP for 19 months after the commencement of MSSP as a managed care benefit.

8. Coordination of Care

In addition to Exhibit A, Attachment 11, Case Management and 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 they have 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

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

performing a risk stratification 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 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 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, and LTC with a focus on transitions;
 - 3) Coordinate with county agencies and Providers, if applicable, for necessary and appropriate behavioral health services; and
 - 4) Follow the requirements for Person-Centered Planning set forth for SPD Beneficiaries in this Contract as stated in Exhibit A, Attachment 11, Case Management and Coordination of Care, Provision 1, Comprehensive Case Management Including Coordination of Care Services.

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

- 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 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 nurses, social workers, Primary Care Providers, and if appropriate, other medical, Behavioral Health, or Providers of CBAS, MSSP, and LTC care coordinators.
- 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.
 - 1) DHCS shall provide the Medicare claims data through its Benefits Coordination and Recovery Center (BCRC).

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

- 2) Contractor shall be responsible for any coordination, testing, and implementation activities necessary to ensure that it is able to receive Medicare claims data. DHCS shall provide ongoing support through BCRC to aid Contractor in preparing and continuing to receive Medicare claims data
 - 3) Use of data is limited to the coordination and reimbursement of Med-Cal benefits and services not covered by Medicare in accordance with All Plan Letter APL 13-001.
- P. For the purpose of Care Coordination with Members receiving IHSS from the 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.

9. Member Services

- A. In addition to Exhibit A, Attachment 13, Member Services, Contractor shall include in its Provider Directory MSSP Provider sites, and all contracted LTC 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.

10. 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. The number of Members receiving CBAS, and/or MSSP in the community, along with number of Members receiving LTC in a facility. 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

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

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 13, Member Services, Provision 3. Call Center Reports, Contractor shall report to DHCS on Member calls related to LTC, CBAS, and MSSP within the quarterly Call Center Report submission. The quarterly Call Center Report submission shall also include calls related to MSSP Grievances and Appeals, and whether Contractor has referred any Grievances or Appeals to the MSSP site.
- E. 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. Contractor shall not be responsible for reporting Grievances, Appeals, or resolutions related to a Member receiving MSSP services if they were reported to the MSSP site.
- F. Contractor shall report to DHCS the number of Partial Dual Eligible or Medi-Cal Only Members who were assigned to a Primary Care Provider on a monthly basis and in a format specified by DHCS

11. 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 provisions of all Covered Services for Full Benefit Dual Eligible Members.
- B. A risk corridor shall also 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 and applies only to the provision of MLTSS Covered Services and IHSS for Partial Dual Eligible Members and Medi-Cal Only Members.
- C. Gains and losses are defined as the Capitated Revenues minus the sum of Adjusted Service Expenditures for applicable services, as described in

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

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 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

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

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 Service 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.
 - a) For the purposes of this Contract, the region is defined as The Northern Counties Region, which includes San Mateo and Santa Clara counties.
 - b) If two (2) or fewer counties are operational within a region, experience from other counties outside of the region 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.

12. Capitation Rate Structure for Full Benefit Dual Eligible Members

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

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. These Full Benefit Dual Eligible Members shall also be grouped into four (4) Member mix categories representing differing levels of risk. Effective January 1, 2018, these categories are defined as follows:

- 1) Institutionalized; Members in LTC aid codes and/or residing in a LTC facility for 90 days or more;
- 2) CBAS and MSSP Members meet one (1) or more of the following criteria:
 - a) Members who receive CBAS; or
 - b) Members who are clients of MSSP sites.
- 3) IHSS Only (no CBAS or MSSP): Members who receive IHSS, but do not receive CBAS and are not clients of a MSSP site; and
- 4) Community Well; Members living in the community with no covered HCBS, are not residents in LTC facilities, and do not utilize CBAS, MSSP, or IHSS services.

C. The capitation rate will utilize the following payment methodology:

- 1) DHCS shall initially pay an estimated rate based on the assumed mix across the three (3) population segments and four (4) Member

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

mix categories. This assumed mix is impacted by a DHCS assumption related to the percentage of Members who will opt out of Cal MediConnect.

- 2) DHCS shall recalculate the blended rate based on the actual Full Benefit Dual Eligible Member distribution beginning no later than January 1, 2015 when actual Full Benefit Dual Eligible Member enrollment is known. The final rate based on the actual enrollment distribution will incorporate the same base rates by population segment and Member mix category as the original estimated rate. DHCS shall always retain the ability to group Members into the three (3) population segments and four (4) Member mix categories.
 - 3) The final Member mix calculations will be completed after the recalculation time frames, either quarterly or annually as referenced in each respective Phase identified in Paragraph D of this Provision.
 - 4) Once DHCS has recalculated the blended rate, there may be additional payments by DHCS to Contractor or a recoupment of Overpayment from Contractor to DHCS.
- D. The payment process will include two (2) distinct phases to address the stability of enrollment and to establish appropriate financial incentives for Contractor.
- 1) Phase I: This phase will be for one (1) fiscal quarter. The recalculation of the final rate will be prospectively applied on April 1, 2014 and again for a second quarter from July 2014 through September 2014 after which Contractor will move into Phase II.
 - 2) Phase II: Contractor's capitation rates are based on a targeted, relative mix of Members and will not be adjusted during the year. Phase II will begin with the fiscal year starting in October 2014. The targeted relative mix of Members for the year is based on enrollment leading up to the start of the Phase II year and will include an assumed shift in the mix of Members.
 - a) Specific to Phase II, 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.

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

- 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 cost 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 438.6(b)(1) and reviewed by the CMS. Capitation rates approved by CMS will serve as the baseline Medi-Cal costs.
- F) DHCS and its actuaries will provide to CMS the underlying data for the capitation rate calculations associated with this Contract.
- G) As allowed under the capitation rates for this Contract, DHCS and its actuaries will calculate a range of actuarially sound capitation payment rates including lower bound and upper capitation rates.
- H) Limited risk corridors will be applied as described for Contractor and be reconciled after application of any risk adjustment methodologies and any other adjustments

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 Capitation Payments
12. Payment of Aids Beneficiary Rate
13. Medical Loss Ratio (MLR)
14. Adult Expansion Medical Loss Ratio and Risk Corridor
15. Supplemental Payments
16. Special Contract Provisions Related to Payment
17. Medicare Coordination

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 and/or any subsequent years covered under this Contract does not appropriate sufficient funds for the program, this Contract shall be of no further force and effect. In this event, DHCS shall have no liability to pay any funds whatsoever to Contractor or to furnish any other considerations under this Contract and Contractor shall not be obligated to perform any provisions of this Contract.

All payments and rate adjustments are subject to appropriations of funds by the Legislature and may include Department of Finance approval. Further, all payments are subject to the availability of Federal congressional appropriation of funds.

- B. If funding for any fiscal year is reduced or deleted by the Budget Act for purposes of this program, DHCS shall have the option to either cancel this Contract with no liability occurring to the State, or offer an amendment to Contractor to reflect the reduced amount.

2. 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.

3. Capitation Rates

- A. Commencing with the effective date of this Contract, DHCS shall make a postpaid payment to the Contractor no later than the fourth working day of each month following the month of service for which payment is being made. Such payment shall be determined pursuant to two (2) methods:
- 1) For any month where an initial payment was based on the average number of Medi-Cal Eligible Beneficiary counts in each aid code as set forth on the Medi-Cal Eligibility Data System (MEDS), eligibility files for the fourth, fifth, and sixth months preceding the month for which payment is covered, DHCS shall continue to pay based on the 6th and 12th month reconciliations provisions in Exhibit B, Provision 5 until completion of the 12 month reconciliations for all prior

Exhibit B
BUDGET DETAIL AND PAYMENT PROVISIONS

months where an average payment has been made.

- 2) For the period beginning with the date of this Contract, DHCS shall make a postpaid payment to the Contractor for the month of service and all retroactivity included within that month. Such payment shall be determined by multiplying the capitation rates for each aid code, according to the capitation rate schedule below, by the number of Medi-Cal Eligible Beneficiary counts in each aid code as set forth on MEDS and eligibility files. The payments shall be made in accordance with the following schedule of rates:

For the period 07/01/15 – 06/30/16	County
Aid Groups	Rates
Adult & Family/Optional Targeted Low-Child (Under 19)	
Adult & Family/Optional Targeted Low-Child (19 & Older)	
Family & Dual Eligible	
Aged & Disabled Medi-Cal Only	
Disabled/Dual Eligible	
Aged/Dual Eligible	
Long Term Care/Full Dual Eligible	
Long Term Care/Non-Full Dual Eligible	
Breast and Cervical Cancer Treatment Program (BCCTP)	
AIDS/Dual Eligible	
AIDS/Medi-Cal Only	
Maternity	
Adult Expansion	
Maternity Expansion	

Exhibit B
BUDGET DETAIL AND PAYMENT PROVISIONS

For the period 07/01/16 – 06/30/17	County
Aid Groups	Rates
Adult & Family/Optional Targeted Low-Income Child (Under 19)	
Adult & Family/Optional Targeted Low-Income Child (19 & Older)	
Family & Dual Eligible	
Aged & Disabled Medi-Cal Only	
Disabled/Dual Eligible	
Aged/Dual Eligible	
Long Term Care/Full Dual Eligible	
Long Term Care/Non-Full Dual Eligible	
Breast and Cervical Cancer Treatment Program (BCCTP)	
AIDS/Dual Eligible	
AIDS/Medi-Cal Only	
Maternity	
Adult Expansion	
Maternity Expansion	

For the period 07/01/17 – 06/30/18	County
Aid Groups	Rates
Adult & Family/Optional Targeted Low-Income Child (Under 19)	
Adult & Family/Optional Targeted Low-Income Child (19 & Older)	
Family & Dual Eligible	
SPD	
SPD/Dual Eligible	
Long Term Care/Full Dual Eligible	
Long Term Care/Non-Full Dual Eligible	
Breast and Cervical Cancer Treatment Program (BCCTP)	
Maternity	
Adult Expansion	
Maternity Expansion	
Hep C 340B	
Hep C Non-340B	
HCBS High	
HCBS Low	
BHT/Ages 0-6	
BHT/Ages 7-20	

Exhibit B
BUDGET DETAIL AND PAYMENT PROVISIONS

For the period 06/30/18 – 12/31/18	County
Groups	Rates
Adult & Family/Optional Targeted Low-Income Child (Under 19)	
Adult & Family/Optional Targeted Low-Income Child (19 & Older)	
Family & Dual Eligible	
SPD	
SPD/Dual Eligible	
Long Term Care/Full Dual Eligible	
Long Term Care/Non-Full Dual Eligible	
Breast and Cervical Cancer Treatment Program (BCCTP)	
Maternity	
Adult Expansion	
Maternity Expansion	
Hepatitis C/340B	
Hepatitis C/Non-340B	
HCBS High	
HCBS Low	
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 monthly capitation rate specified for the original aid code. DHCS shall confirm all aid code splits, and the rates of payment for such new aid codes, in writing to Contractor as soon as practicable after such aid code splits occur.
- C. Pursuant to Title 42 CFR 438.6(b)(1), the actuarial basis for the computation of the Capitation Payment rates shall be set for in DHCS' most recent version of the annually-published Rate Manual for the rate period that is identified above. Said Rate Manual is incorporated by reference in Exhibit E, Provision 1.
- 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 from DHCS to Contractor of the capitated rates for Dual payment rates not

Exhibit B
BUDGET DETAIL AND PAYMENT PROVISIONS

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 during the Phase II process, which is described in Exhibit A, Attachment 23, Managed Long-Term Services and Supports, Provision 12, Capitation Rate Structure for Full Benefit Dual Eligible Members, Section D.

- 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.

4. Capitation Rates Constitute Payment In Full

The capitation payment constitutes payment in full on behalf of a Member for all Covered Services required by the Member and for all Administrative Costs incurred by the Contractor in providing or arranging for those services. It does not include payment for the recoupment of current or previous losses incurred by Contractor. DHCS is not responsible for making payments for recoupment of losses.

5. Reconciliation of Payments with Counts of Eligible Beneficiaries

- A. Within 15 days of the completion of the 6th month and of the 12th month following a month for which capitation was paid in accordance with the method described in Exhibit B, Provision 3, Paragraph A.1) above, the State shall determine the difference between the actual number of Eligible Beneficiaries and the number of Eligible Beneficiaries for which payment had been made. In determining the actual number of Eligibles, the State shall count as County Eligibles:
 - 1) Those Eligible Beneficiaries for whom immediate need Medi-Cal cards have been issued.
 - 2) Those Eligible Beneficiaries who have been recorded with eligibility listings provided for in Exhibit E, Attachment 3, Provision 4. Enrollment and Disenrollment Processing but who have subsequently been deleted from that listing if the Contractor demonstrates that service was rendered during the month under consideration.
- B. The numerical difference shall be multiplied by the Capitation Rate for each aid code category, pursuant to Exhibit B, Provision 3. Capitation Rates. If the actual number of Members is greater than the number for

Exhibit B
BUDGET DETAIL AND PAYMENT PROVISIONS

which payment had been made, the resultant amount of the above multiplication shall be credited to the Contractor, and the Contractor shall be paid capitation rates for these Members. If the actual number of Members is less than the number for which payment had been made, the resultant amount of the above multiplication shall be credited to the State and withheld from the Contractor's next capitation payment.

6. Determination of Rates

- A. DHCS shall determine the capitation rates from the Contract effective date of operations through June 30, 2009. Subsequent to June 30, 2009 and through the duration of the Contract, DHCS shall make an annual redetermination of rates for each rate year defined as the 12-month period from July 1, through June 30. DHCS reserves the right to establish or negotiate rates on an actuarial basis or move to a negotiated rate for each rate year. All payments and rate adjustments are subject to appropriations of funds by the Legislature and the Department of Finance approval. Further, all payments are subject to the availability of Federal congressional appropriation of funds.
- B. If DHCS establishes rates on an actuarial basis, it shall determine whether the rates shall be increased, decreased, or remain the same. If it is determined by DHCS that Contractor's capitation rates shall be increased or decreased, the increase or decrease shall be effectuated through an amendment to this Contract in accordance with the provisions of Exhibit E, Attachment 2, Provision 3. Amendment Process, subject to the following provisions:
 - 1) An amendment shall be effective as of July 1 of each year covered by this Contract.
 - 2) In the event there is any delay in a determination to increase or decrease capitation rates, so that an amendment may not be processed in time to permit payment of new rates commencing July 1, the payment to Contractor shall continue at the rates then stated in an R Letter sent to the 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 an amendment and rate certification providing for the rate change, DHCS shall make retroactive adjustments for those months for which interim payment was made.

Exhibit B
BUDGET DETAIL AND PAYMENT PROVISIONS

7. Rate Year

The rate year for this Contract is July 1 through June 30.

8. Redetermination of Rates – Obligation Changes

The capitation rates may be adjusted during the rate year to provide for a change in obligations required by Federal or State regulations, or required by a change in the interpretation or implementation of any such law or regulation. Any adjustments shall be effectuated through an amendment to this Contract in accordance with the provisions of Exhibit E, Attachment 2, Provision 3. Amendment Process, subject to the following provisions:

- A. An amendment 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 an amendment in time to permit payment of the adjusted rates as of the month in which the change in obligations is effective, payment to Contractor shall continue at the rates then in effect. Continued payment shall constitute interim payment only. Upon final approval of an amendment providing for the change in obligations, DHCS shall make adjustments for those months for which interim payment was made.
- C. In addition to DHCS' re-determination of capitation rates, Contractor's capitation rates shall be adjusted for any increase or decrease in Long Term Care (LTC) payment rates as mandated by the Legislature, approved by the Governor, and that does not violate Federal law. Any LTC rate increase or decrease may be affected through an amendment to this Contract in accordance with Exhibit E, Attachment 2, Provision 3. Amendment Process.

9. 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.

Exhibit B
BUDGET DETAIL AND PAYMENT PROVISIONS

10. Catastrophic Coverage Limitation

DHCS may limit the Contractor's liability to provide or arrange and pay for care for illness of, or injury to Members, which results from or is greatly aggravated by, a catastrophic occurrence or disaster. Contractor will return a prorated amount of the Capitation Payment following the DHCS Director's invocation of the catastrophic coverage limitation. The amount returned will be determined by dividing the total Capitation Payment by the number of days in the month. The amount will be returned to DHCS for each day in the month after the Director has invoked the Catastrophic Coverage Limitation clause.

11. Financial Performance Guarantee

If capitation is paid at the beginning of the month for the months of service, Contractor shall provide satisfactory evidence of and maintain Financial Performance Guarantee in an amount equal to at least one (1) month's Capitation Payment, in a manner specified by DHCS. At the Contractor's request, and with DHCS approval, Contractor may establish a phase-in schedule to accumulate the required Financial Performance Guarantee. The Financial Performance Guarantee shall remain in effect for a period not exceeding 90 calendar days following termination or expiration of this Contract or unless DHCS has a financial claim against Contractor. Contractor may elect to satisfy the Financial Performance Guarantee requirement by receiving payment at the end of the month for the month of service, the requirement for the Financial Performance Guarantee will be considered satisfied by the DHCS. Further rights and obligations of the Contractor and DHCS, in regards to Financial Performance guarantee, shall be as specified in Title 22 CCR 53865. This provision is not applicable to Contractor's that are paid capitation for retroactive months of eligibility and must pay claims for services provided during that eligibility, and that undergo a reconciliation of payments with counts of Eligible Beneficiaries.

12. Recovery of Capitation Payments

DHCS shall have the right to recover from Contractor amounts paid to Contractor in the following circumstances as specified:

- A. If DHCS determines that a Member has either been improperly enrolled due to ineligibility of the Member to enroll in Contractor's plan, residence outside of Contractor's Service Area, or should have been disenrolled with an effective date in a prior month, DHCS may recover the Capitation Payments made to Contractor for the Member for the month(s) in question. 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

Exhibit B
BUDGET DETAIL AND PAYMENT PROVISIONS

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.

- B. As a result of Contractor's failure to perform contractual responsibilities to comply with mandatory Federal Medicaid requirements, the Federal Department of Health and Human Services (DHHS) may disallow Federal Financial Participation (FFP) for payments made by DHCS to Contractor. DHCS may recover the amounts disallowed by DHHS by an offset to the Capitation Payments made to Contractor. If recovery of the full amount at one time imposes a financial hardship on Contractor, DHCS at its discretion may grant a Contractor's request to repay the recoverable amounts in monthly installments over a period of consecutive months not to exceed six (6) months.
- 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 the Capitation Payments made to Contractor in accordance with Welfare and Institutions Code Section 14115.5. At least 30 days prior to seeking such recovery, DHCS shall inform Contractor about the improper payment, and the overpayment to Contractor shall be recaptured by DHCS withholding the amount due from Contractor's next capitation check. If the amount to be withheld from that capitation check exceeds 25 percent of the capitation payment for that month, amounts up to 25 percent shall be withheld from successive capitation payments until the overpayment is fully recovered by DHCS.

13. Payment of AIDS Capitation Rates for Members with AIDS

The Contractor shall be entitled to claim and be reimbursed at the AIDS capitation rate in lieu of any other capitation payment made for Member with AIDS in any month as follows:

- A. Capitation payments at the AIDS capitation rate shall commence effective with the first month in which the Confirmed Diagnosis of AIDS under the applicable CDC definition is made for a Member;
- B. Contractor shall submit an invoice for each month to DHCS. The invoice shall include the following:
 - 1) a listing of all Members with AIDS identified by Medi-Cal numbers only, for whom Contractor is claiming the AIDS rate;

Exhibit B
BUDGET DETAIL AND PAYMENT PROVISIONS

- 2) the month(s) and year(s) for which the AIDS rate is being claimed for each Member listed;
 - 3) the capitation rate initially paid for the Member for each month being claimed by Contractor, and the adjusted amount due Contractor for each Member; and
 - 4) the total amount being claimed on the invoice.
- C. The listing submitted in the thirteenth month following any month of eligibility shall be the final listing on which Contractor is entitled to claim the AIDS rate for that month of eligibility;
- D. DHCS shall verify the Medi-Cal eligibility of each Member for whom the AIDS rate is claimed and adjust the invoiced amounts to reflect any capitation payments which have previously been made to the Contractor for each Member prior to submittal of the invoice required by subparagraph B. above;
- E. DHCS shall process the AIDS rate invoices, calculate payments, and submit the necessary paper work to DHCS' accounting section within 25 work days of invoice receipt; and
- F. When DHCS determines by subsequent review that a Member for whom capitation has been paid at the AIDS rate did not meet the definition of a Member with AIDS as specified in this Contract, in a month for which the AIDS rate was paid, DHCS shall recoup any amount improperly paid, by an offset to the capitation payment and shall set forth its reasons for the recoupment. DHCS shall give written notice to Contractor 30 calendar days prior to any such offset.

14. 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

Exhibit B
BUDGET DETAIL AND PAYMENT PROVISIONS

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.

- 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:

Exhibit B
BUDGET DETAIL AND PAYMENT PROVISIONS

- 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:
 - 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

Exhibit B
BUDGET DETAIL AND PAYMENT PROVISIONS

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).
 - 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

Exhibit B
BUDGET DETAIL AND PAYMENT PROVISIONS

- 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.
 - 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.

Exhibit B
BUDGET DETAIL AND PAYMENT PROVISIONS

- 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 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 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

Exhibit B
BUDGET DETAIL AND PAYMENT PROVISIONS

- 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.
 - 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 subcontracting limitations, to calculate and validate the accuracy of

Exhibit B
BUDGET DETAIL AND PAYMENT PROVISIONS

- 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.

15. 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).

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, 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, at least through

Exhibit B
BUDGET DETAIL AND PAYMENT PROVISIONS

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 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

Exhibit B
BUDGET DETAIL AND PAYMENT PROVISIONS

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 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, or 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.

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

Exhibit B
BUDGET DETAIL AND PAYMENT PROVISIONS

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.

16. 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) Commencing on January 1, 2018, 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 and who

Exhibit B
BUDGET DETAIL AND PAYMENT PROVISIONS

utilize such services on or after January 1, 2018.

- 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.

17. Supplemental Payments

A. Contractor shall be entitled to supplemental 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 supplemental payment. Failure to have supporting records may, upon audit, result in recoupment by DHCS of the supplemental payment.

- 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 Medi-Cal Managed Care Supplemental Payments. This report shall identify the Members receiving services qualifying for supplemental 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 supplemental payment.
 - b) After the fourteenth month following the month of service, Contractor will not receive a supplemental payment.

B. Supplemental Maternity Payment

- 1) Contractor shall be entitled to receive a Supplemental Maternity Payment for Members enrolled with Contractor on the date of the delivery of a child, including retroactive enrollments.
- 2) The Supplemental Maternity Payment reimburses Contractor for the cost of delivery, and is in addition to the monthly Capitation Rate paid by DHCS to Contractor for the Member.

C. Hepatitis C Prescriptions

Exhibit B
BUDGET DETAIL AND PAYMENT PROVISIONS

- 1) Contractor shall be paid a monthly supplemental payment based on a weekly rate for each Member who receives prescriptions for Hepatitis C (Hep C) drugs. Payments are based on the Member's utilization as reported by Contractor. The payment period for health care services shall commence on July 1, 2014.
 - 2) Contractor shall receive a supplemental payment for each Member who receives prescriptions for Hep C drugs in addition to the monthly Capitation Payment.
- D. Supplemental Rate 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:
 - a) 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.
 - b) HCBS High: Members who are at a high risk for institutionalization based on an IHSS classification of "Severely Impaired", or are in the MSSP 1915(c) waiver, or are receiving CBAS as defined by Contractor.
 - c) HCBS Low: Members who have an IHSS classification of "Not Severely Impaired".
 - 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. Payments for Members identified as HCBS High or HCBS Low will be made in addition to any other monthly rate payments sent for the

Exhibit B
BUDGET DETAIL AND PAYMENT PROVISIONS

Member for the same month of service.

E. Supplemental Payment for BHT Services

Contractor shall be paid a monthly supplemental payment for each Member who receives BHT services. Payments shall be based on the Member's utilization as reported by Contractor in accordance with the requirements in Exhibit B. The payment period for health care services shall commence on September 15, 2014.

18. Special Contract Provisions Related to Payment

Contractor shall comply with 42 CFR 438.6 in a form and manner specified by DHCS.

19. 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 Dual-Eligible Beneficiary Members.

Exhibit D(F)
SPECIAL TERMS AND CONDITIONS

1. Federal Equal Opportunity Requirements

- A. The Contractor will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. The Contractor will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. The Contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973 and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 USC 4212). Such notices shall state the Contractor's obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.
- B. The Contractor will, in all solicitations or advancements for employees placed by or on behalf of the Contractor, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.
- C. The Contractor will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of the Contractor's commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.
- D. The Contractor will comply with all provisions of and furnish all

**Exhibit D(F)
SPECIAL TERMS AND CONDITIONS**

information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 USC 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

- E. The Contractor will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.
- F. In the event of the Contractor's noncompliance with the requirements of the provisions herein or with any Federal rules, regulations, or orders which are referenced herein, this Contract may be cancelled, terminated, or suspended in whole or in part and the Contractor may be declared ineligible for further Federal and state contracts in accordance with procedures authorized in Federal Executive Order No. 11246 as amended and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.
- G. The Contractor will include the Provisions of Paragraphs A through G in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order

Exhibit D(F)
SPECIAL TERMS AND CONDITIONS

11246 Relating to Equal Employment Opportunity,‘ and as supplemented by regulation at 41 CFR 60, “Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor,” or Section 503 of the Rehabilitation Act of 1973 or (38 USC 4212) of the Vietnam Era Veteran’s Readjustment Assistance Act, so that such provisions will be binding upon each subcontractor or vendor. The Contractor will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions including sanctions for noncompliance provided, however, that in the event the Contractor becomes involved in, or is threatened with litigation by a subcontractor or vendor as a result of such direction by DHCS, the Contractor may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

2. Travel and Per Diem Reimbursement

[Intentionally Left Blank – Not applicable to this Contract]

3. Procurement Rules

[Intentionally Left Blank – Not applicable to this Contract]

4. Equipment Ownership / Inventory / Disposition

[Intentionally Left Blank – Not applicable to this Contract]

5. Subcontract Requirements

[Intentionally Left Blank – Not applicable to this Contract]

6. Income Restrictions

[Intentionally Left Blank – Not applicable to this Contract]

7. Audit and Record Retention

[Intentionally Left Blank – Not applicable to this Contract]

8. Site Inspection

The State, through any authorized representatives, has the right at all reasonable times to inspect or otherwise evaluate the work performed or

Exhibit D(F)
SPECIAL TERMS AND CONDITIONS

being performed hereunder including subcontract supported activities and the premises in which it is being performed. If any inspection or evaluation is made of the premises of the Contractor or Subcontractor, the Contractor shall provide and shall require Subcontractors to provide all reasonable facilities and assistance for the safety and convenience of the authorized representatives in the performance of their duties. All inspections and evaluations shall be performed in such a manner as will not unduly delay the work.

9. Federal Contract Funds

- A. It is mutually understood between the parties that this Contract may have been written before ascertaining the availability of congressional appropriation of funds, for the mutual benefit of both parties, in order to avoid program and fiscal delays which would occur if the Contract were executed after that determination was made.
- B. This Contract is valid and enforceable only if sufficient funds are made available to the State by the United States Government for the fiscal years covered by the term of this Contract. In addition, this Contract is subject to any additional restrictions, limitations, or conditions enacted by the Congress or any statute enacted by the Congress that may affect the provisions, terms or funding of this Contract in any manner.
- C. It is mutually agreed that if the Congress does not appropriate sufficient funds for the program, this Contract shall be amended to reflect any reduction in funds.
- D. DHCS has the option to invalidate or cancel the Contract with 30-days advance written notice or to amend the Contract to reflect any reduction in funds.

10. Intellectual Property Rights

[Intentionally Left Blank – Not applicable to this Contract]

11. Air or Water Pollution Requirements

Any federally funded agreement and/or subcontract in excess of \$100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR 15.5

- A. Government contractors agree to comply with all applicable

Exhibit D(F)
SPECIAL TERMS AND CONDITIONS

standards, orders, or requirements issued under section 306 of the Clean Air Act [42 USC 1857(h)], section 508 of the clean Water Act (33 USC 1368), Executive Order 11738, and Environmental Protection Agency regulations (40 CFR part 15).

- B. Institutions of higher education, hospitals, nonprofit organizations and commercial businesses agree to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 USC 1251 et seq.), as amended.

12. Prior Approval of Training Seminars, Workshops or Conferences

[Intentionally Left Blank – Not applicable to this Contract]

13. Confidentiality of Information

- A. The Contractor and its employees, agents, or subcontractors shall protect from unauthorized disclosure names and other identifying information concerning persons either receiving services pursuant to this Contract or persons whose names or identifying information become available or are disclosed to the Contractor, its employees, agents, or subcontractors as a result of services performed under this Contract, except for statistical information not identifying any such person.
- B. The Contractor and its employees, agents, or subcontractors shall not use such identifying information for any purpose other than carrying out the Contractor's obligations under this Contract.
- C. The Contractor and its employees, agents, or subcontractors shall promptly transmit to the DHCS program contract manager all requests for disclosure of such identifying information not emanating from the client or person.
- D. The Contractor shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the client, any such identifying information to anyone other than DHCS without prior written authorization from the DHCS program contract manager.
- E. For purposes of this Provision, identity shall include, but not be limited to name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

Exhibit D(F)
SPECIAL TERMS AND CONDITIONS

- F. As deemed applicable by DHCS, this Provision may be supplemented by additional terms and conditions covering personal health information (PHI) or personal, sensitive, and/or confidential information (PSCI). Said terms and conditions will be outlined in one or more exhibits that will either be attached to this Contract or incorporated into this Contract by reference.

14. Documents, Publications and Written Reports

[Intentionally Left Blank – Not applicable to this Contract]

15. Dispute Resolution Process

[Intentionally Left Blank – Not applicable to this Contract]

16. Financial and Compliance Audit Requirements

[Intentionally Left Blank – Not applicable to this Contract]

17. Human Subjects Use Requirements

By signing this Contract, Contractor agrees that if any performance under this Contract or any subcontract includes any tests or examination of materials derived from the human body for the purpose of providing information, diagnosis, prevention, treatment or assessment of disease, impairment, or health of a human being, all locations at which such examinations are performed shall meet the requirements of 42 USC 263a (CLIA) and the regulations thereto.

18. Novation Requirements

[Intentionally Left Blank – Not applicable to this Contract]

19. Debarment and Suspension Certification

- A. By signing this Contract, the Contractor agrees to comply with applicable Federal suspension and debarment regulations including, but not limited to 7 CFR 3017, 45 CFR 76, 40 CFR 32, or 34 CFR 85.
- B. By signing this Contract, the Contractor certifies to the best of its knowledge and belief, that it and its principals:
- 1) Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by

**Exhibit D(F)
SPECIAL TERMS AND CONDITIONS**

any Federal department or agency;

- 2) Have not within a three-year period preceding this Contract have been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
 - 3) Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in Subprovision B.(2) herein; and
 - 4) Have not within a three-year period preceding this Contract had one or more public transactions (Federal, State or local) terminated for cause or default.
 - 5) Shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under Federal regulations (i.e., 48 CFR 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State.
 - 6) Will include a clause entitled, "Debarment and Suspension Certification" that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.
- C. If the Contractor is unable to certify to any of the statements in this certification, the Contractor shall submit an explanation to the DHCS program funding this Contract.
- D. The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.
- E. If the Contractor knowingly violates this certification, in addition to other remedies available to the Federal Government, the DHCS may terminate this Contract for cause or default.

Exhibit D(F)
SPECIAL TERMS AND CONDITIONS

20. Smoke-Free Workplace Certification

- A. Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through state or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed.
- B. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible party.
- C. By signing this Contract, Contractor certifies that it will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The prohibitions herein are effective December 26, 1994.
- D. Contractor further agrees that it will insert this certification into any subcontracts entered into that provide for children's services as described in the Act.

21. Covenant Against Contingent Fees

The Contractor warrants that no person or selling agency has been employed or retained to solicit/secure this Contract upon an agreement of understanding for a commission, percentage, brokerage, or contingent fee, except *bona fide* employees or *bona fide* established commercial or selling agencies retained by the Contractor for the purpose of securing business. For breach or violation of this warranty, DHCS shall have the right to annul this Contract without liability or in its discretion to deduct from the Contract price or consideration, or otherwise recover, the full amount of such commission, percentage, and brokerage or contingent fee.

Exhibit D(F)
SPECIAL TERMS AND CONDITIONS

22. Payment Withholds

[Intentionally Left Blank – Not applicable to this Contract]

23. Performance Evaluation

DHCS may, at its discretion, evaluate the performance of the Contractor at the conclusion of this Contract. If performance is evaluated, the evaluation shall not be a public record and shall remain on file with DHCS. Negative performance evaluations may be considered by DHCS prior to making future contract awards.

24. Officials Not to Benefit

No members of or delegate of Congress or the State Legislature shall be admitted to any share or part of this Contract, or to any benefit that may arise therefrom. This Provision shall not be construed to extend to this Contract if made with a corporation for its general benefits.

25. Four-Digit Date Compliance

[Intentionally Left Blank – Not applicable to this Contract]

26. Prohibited Use of State Funds for Software

Contractor certifies that it has appropriate systems and controls in place to ensure that State funds will not be used in the performance of this Contract for the acquisition, operation or maintenance of computer software in violation of copyright laws.

27. Use of Small, Minority Owned and Women's Businesses

[Intentionally Left Blank – Not applicable to this Contract]

28. Alien Ineligibility Certification

By signing this Contract, the Contractor certifies that he/she is not an alien that is ineligible for State and local benefits, as defined in Subtitle B of the Personal Responsibility and Work Opportunity Act. (8 USC 1601, et seq.)

29. Union Organizing

[Intentionally Left Blank – Not applicable to this Contract]

30. Contract Uniformity (Fringe Benefit Allowability)

Exhibit D(F)
SPECIAL TERMS AND CONDITIONS

[Intentionally Left Blank – Not applicable to this Contract]

31. Lobbying Restrictions and Disclosure Certification

(Applicable to federally funded contracts in excess of \$100,000 per Section 1352 of the 31, U.S.C.)

A. Certification and Disclosure Requirements

- 1) Each person (or recipient) who requests or receives a contract, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds \$100,000 at any tier, shall file a certification (in the form set forth in Attachment 1, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Paragraph b of this provision.
- 2) Each recipient shall file a disclosure (in the form set forth in Attachment 2, entitled "Standard Form-LLL 'disclosure of Lobbying Activities'") if such recipient has made or has agreed to make any payment using nonappropriated funds (to include profits from any covered federal action) in connection with a contract or grant or any extension or amendment of that contract or grant, which would be prohibited under Paragraph b of this provision if paid for with appropriated funds.
- 3) Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by such person under Paragraph a(2) herein. An event that materially affects the accuracy of the information reported includes:
 - a) A cumulative increase of \$25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action;
 - b) A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or
 - c) A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting

**Exhibit D(F)
SPECIAL TERMS AND CONDITIONS**

to influence a covered federal action.

- 4) Each person (or recipient) who requests or receives from a person referred to in Paragraph a(1) of this provision a contract, subcontract, grant or subgrant exceeding \$100,000 at any tier under a contract or grant shall file a certification, and a disclosure form, if required, to the next tier above.
- 5) All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Paragraph a(1) of this provision. That person shall forward all disclosure forms to DHCS program contract manager.

B. Prohibition

Section 1352 of Title 31, U.S.C., provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

Exhibit E
ADDITIONAL PROVISIONS

1. Additional Incorporated Exhibits

A. The following additional exhibits are attached, incorporated herein, and made a part hereof by this reference:

1. Exhibit A, Attachment 1 - Organization and Administration of the Plan
2. Exhibit A, Attachment 2 - Financial Information
3. Exhibit A, Attachment 3 - Management Information System
4. Exhibit A, Attachment 4 - Quality Improvement System
5. Exhibit A, Attachment 5 - Utilization Management
6. Exhibit A, Attachment 6 - Provider Network
7. Exhibit A, Attachment 7 - Provider Relations
8. Exhibit A, Attachment 8 - Provider Compensation Arrangements
9. Exhibit A, Attachment 9 - Access and Availability
10. Exhibit A, Attachment 10 - Scope of Services
11. Exhibit A, Attachment 11 - Case Management and Coordination of Care
12. Exhibit A, Attachment 12 - Local Health Department Coordination
13. Exhibit A, Attachment 13 - Member Services
14. Exhibit A, Attachment 14 - Member Grievance System
15. Exhibit A, Attachment 15 - Marketing
16. Exhibit A, Attachment 16 - Enrollments and Disenrollments
17. Exhibit A, Attachment 17 - Reporting Requirements
18. Exhibit A, Attachment 18 - Implementation Plan and Deliverables
19. Exhibit A, Attachment 19 - Community Based Adult Services (CBAS)
20. Exhibit A, Attachment 20 - Mental Health and Substance Use Disorder Benefits
21. Exhibit A, Attachment 21 - Managed Long-Term Services and Supports

B. The following documents and any subsequent updates are not attached, but are incorporated herein and made a part hereof by this reference. These documents may be updated periodically by DHCS, as required by program directives. DHCS shall provide the Contractor with copies of said documents and any periodic updates thereto, under separate cover. DHCS will maintain on file, all documents referenced herein and any subsequent updates.

- 1) Rate Manual

**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.

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.

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

Adult Day Health Care (ADHC) means an organized day program of therapeutic, social and health activities and services provided to persons 55

Exhibit E, Attachment 1
DEFINITIONS

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 for in Title 22, Section 78007 of the California Code of Regulations.

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 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 revenues 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. 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. 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.

Advance Directives means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law.

Affiliate means an organization or person that directly or indirectly through one or more intermediaries' controls, or is controlled by, or is under control with the

Exhibit E, Attachment 1
DEFINITIONS

Contractor and that provides services to, or receives services from, the Contractor.

AIDS Beneficiary means a Member for whom a Diagnosis of Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) has been made by a treating Physician based on the definition most recently published in the Mortality and Morbidity Report from the Centers for Disease Control and Prevention.

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 Care 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 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 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. 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.
- B. 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.
- C. 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 rating region. Related parties are defined by GAAP.

**Exhibit E, Attachment 1
DEFINITIONS**

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.

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 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 determinations, 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.

Exhibit E, Attachment 1
DEFINITIONS

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 services approved in the State Plan such as Applied Behavior Analysis (ABA) and other evidence-based behavioral interventions to prevent or minimize the adverse effects of ASD and promote, to the maximum extent practicable, the functioning of a Member. These services are interventions designed to treat ASD, and include 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.

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 Services (CCS) Eligible Conditions means a physically handicapping condition defined in Title 22, California Code of Regulations (CCR), Section 41800.

California Children Services (CCS) Program means the public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of 21 years who have CCS eligible conditions.

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 Members, 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.

**Exhibit E, Attachment 1
DEFINITIONS**

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, Comprehensive Medical Case Management Services, Person Centered Planning and Discharge Planning, and are included as part of a functioning Medical Home.

Catastrophic Coverage Limitation means the date beyond which Contractor is not at risk, as determined by the Director, to provide or make reimbursement for illness of or injury to beneficiaries which results from or is greatly aggravated by a catastrophic occurrence or disaster, including, but not limited to, an act of war, declared or undeclared, and which occurs subsequent to enrollment.

Child Health and Disability Prevention (CHDP) Program means those preventive health care services for beneficiaries under 21 years of age provided in accordance with the provisions of Health and Safety Code Section 124025, et seq., and Title 17, CCR, Sections 6842 through 6852.

Children with Special Health Care Needs (CSHCN) are defined as children who have or are at increased risk for chronic physical, behavioral, developmental, or emotional conditions, and who also require health care or related services of a type or amount beyond that required by children generally. The identification, assessment, treatment, and coordination of care for CSHCN shall comply with the requirements of Title 42, CFR, Sections 438.208(b)(3) and (b)(4), and 438.208(c)(2), (c)(3), and (c)(4).

Claims and Eligibility Real-Time System (CERTS) means the mechanism for verifying a recipient's Medi-Cal or County Medical Services Program (CMSP) eligibility by computer.

Clean Claim means a claim that can be processed without obtaining additional information 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. (See 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

**Exhibit E, Attachment 1
DEFINITIONS**

Members who meet applicable eligibility criteria.

CBAS Discharge Plan of Care means a plan of care prepared by the CBAS Provider for Members who have been determined by Contractor or DHCS to no longer be eligible for CBAS and must include:

- A. The Member's name and ID number
- B. The name(s) of the Member's physician(s)
- C. Date the Notice of Action was issued
- D. Date the CBAS benefit will be terminated
- E. Specific information about the Member's current medical condition, treatments, and medications
- F. A statement of how Enhanced Case Management services will be provided to the Member if eligible for these services
- G. A statement of the Member's right to file a Grievance or Appeal
- H. A space for the Member or the Member's representative to sign and date the Discharge Plan

CBAS Provider means an ADHC center that provides CBAS services 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

**Exhibit E, Attachment 1
DEFINITIONS**

"confidential" by any law, regulations or contractual language.

Contract means this written agreement between DHCS and Contractor.

Contracting Providers means a Physician, Nurse, technician, hospital, home health agency, nursing home, or any other individual or institution that contracts with Contractor to provide medical services to Members.

Coordinate Benefits means the process of utilizing third party liability resources to ensure that the Medi-Cal program is the payer of last resort. This is accomplished by either operating a cost avoidance method of paying claims, when the existence of Medicare or private health coverage is known at the time the claim is processed, or the method of post-payment recovery of the cost of services, if the coverage is identified retroactively.

Corrective Actions means specific identifiable activities or undertakings of the Contractor that address program deficiencies or problems.

Cost Avoid means Contractor requires a Provider to bill all liable third parties and receive payment or proof of denial of coverage from such third parties prior to Contractor paying the Provider for the services rendered.

County Department means the County Department of Social Services (DSS), or other county agency responsible for determining the initial and continued eligibility for the Medi-Cal program.

County Organized Health System (COHS) means a health care organization that contracts with the State Department of Health Care Services to provide comprehensive health care to all eligible Medi-Cal beneficiaries residing in the county, and that is operated directly by a public entity established by a county government pursuant to Section 14087.51 or 14087.54 of the Welfare and Institutions Code, or Chapter 3 (commencing with Section 101675) of Part 4 of Division 101 of the Health and Safety Code.

Covered Services means Medical Case Management and those benefits set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840. Covered Services do not include:

- A. Home and Community Based Services (HCBS) Waiver Program Services as specified in Exhibit A, Attachment 11, Provision 15 regarding Waiver Programs, and Department of Developmental Services (DDS) Administered Medicaid Home and Community Based Services Waiver as specified in Exhibit A, Attachment 11, Provision 11, Paragraph C. *HCBS do not include any service that is available as an EPSDT service, as*

Exhibit E, Attachment 1
DEFINITIONS

described in Title 22, CCR, Sections 51184, 51340 and 51340.1. EPSDT services are covered under this Contract, as specified in Exhibit A, Attachment 10 regarding Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services. California Children Services (CCS) as specified in Exhibit A, Attachment 11, Provision 10.

- B. Specialty Mental Health Services as specified in Exhibit A, Attachment 11, Provision 7.
- C. Short-Doyle/Medi-Cal Mental Health Services.
- D. Specialty Mental Health Services provided by psychiatrists; psychologists; licensed clinical social workers; or marriage, family, and child counselors.
- E. Alcohol and substance abuse treatment services and outpatient heroin detoxification as specified in Exhibit A, Attachment 11, Provision 8.
- F. Directly observed therapy for treatment of tuberculosis as specified in Exhibit A, Attachment 11, Provision 17.
- G. 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 Title 22, CCR, Section 51340.1(b). However, Contractor is responsible for all medical Covered Services necessary to support dental services provided to Members as specified in Exhibit A, Attachment 11, Provision 16 regarding dental services.
- H. Services in any Federal or State governmental hospital.
- I. Any Local Education Agency (LEA) services as specified in Title 22, CCR, Section 51360 and 51190.4 provided pursuant to an Individualized Education Plan (IEP) as set forth in Education Code, Section 56340 et seq. or an Individualized Family Service Plan (IFSP) as set forth in Government Code Section 95020, or LEA services provided under an Individualized Health and Support Plan (IHSP), as described in Title 22, CCR, Section 51360.
- J. Laboratory services provided under the State serum alpha-fetoprotein-testing program administered by the Genetic Disease Branch of DHCS.
- K. Pediatric Day Health Care pursuant to Title 22, CCR, Section 51184(j).
- L. Personal Care Services as defined in Title 22, CCR, Section 51183 and 51350.

**Exhibit E, Attachment 1
DEFINITIONS**

- M. State Supported Services.
- N. Targeted case management services as specified in Title 22, CCR, Sections 51185 and 51351, and as described in Exhibit A, Attachment 11, Provision 4.
- O. Childhood lead poisoning case management provided by Local County health departments.
- P. Services rendered under the Multipurpose Senior Services Program pursuant to Chapter 5 (commencing with Section 94000) of Part 1 of Division 8.5 of the Welfare and Institutions Code.
- Q. 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 Welfare & Institutions Code Section 14133.23, effective January 1, 2006, drug benefits for full-benefit dual eligible beneficiaries who are eligible for drug benefits under Part D of Title XVIII of the Social Security Act (42 USC Section 1395w-101 et seq) are not a Covered Service under this Contract.
- R. Child Health and Disability Prevention health care services to eligible beneficiaries under the age of 21 years of age provided in accordance with the provisions of Title 17, CCR, Section 6800, et. seq.
- S. Optional benefits as set for in Welfare and Institutions Code Section 14131.10, as implemented by the Medi-Cal Fee-For-Service program.
- T. 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.
- U. 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 Credible to account for a difference between the actual and target MLRs that may be due to random statistical variation.

Department of Health and Human Services (DHHS) means the Federal agency responsible for management of the Medicaid program.

**Exhibit E, Attachment 1
DEFINITIONS**

Department of Health Care Services (DHCS) means the single State Department responsible for administration of the Federal Medicaid (referred to as Medi-Cal in California) Program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.

Department of Managed Health Care (DMHC) means the State agency responsible for administering the Knox-Keene Health Care Service Plan Act of 1975.

Diagnosis of AIDS means a clinical diagnosis of AIDS that meets the most recent communicable disease surveillance case definition of AIDS established by the Federal Centers for Disease Control and Prevention (CDC), United States Department of Health and Human Services, and published in the Morbidity and Mortality Weekly Report (MMWR) or its supplements, in effect for the month in which the clinical diagnosis is made.

Dietitian/Nutritionist means a person who is registered or eligible for registration as a Registered Dietitian by the Commission on Dietetic Registration (Business and Professions Code, Chapter 5.65, Sections 2585 and 2586).

Directed Payment Initiative means a CMS-approved payment arrangement described in 42 CFR 438.6(c) that directs certain expenditures made by Contractor under this Contract.

Director means the Director of the State of California Department of Health Care Services.

Discharge Planning means planning that begins at the time of admission to a hospital or institution to ensure that necessary care, services and supports are in place in the community before individuals leave the hospital or institution in order to reduce readmission rates, improve Member and family preparation, enhance Member satisfaction, assure post-discharge follow-up, increase medication safety, and support safe transitions.

Disproportionate Share Hospital (DSH) means a health Facility licensed pursuant to Chapter 2, Division 2, Health and Safety Code, to provide acute inpatient hospital services, which is eligible to receive payment adjustments from the State pursuant to W&I Code, Section 14105.98.

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 has a county code in

Exhibit E, Attachment 1
DEFINITIONS

Contractor's Service Area with one of the following aid codes:

Aid Group	Aid Codes
Adult and Family/Optional Targeted Low Income Child	01, 02, 03, 04, 06, 07, 08, 30, 32, 33, 34, 35, 37, 38, 39, 40, 42, 43, 45, 46, 47, 49, 54, 59, 72, 81, 82, 83, 86, 87, 0A, 0E, 3A, 3C, 3E, 3F, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 4A, 4F, 4G, 4H, 4K, 4L, 4M, 4N, 4S, 4T, 4W, 5K, 7A, 7J, 7S, 7W, 7X, 8P, 8R, E2, E5, K1, M3, M7, P5, P7, P9, 5C, 5D, H1, H2, H3, H4, H5, E6, E7, M5, T1, T2, T3, T4, T5
Family/Dual Eligible	03, 04, 06, 07, 0E, 30, 32, 33, 34, 35, 37, 38, 39, 40, 42, 43, 45, 46, 49, 3E, 3F, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 4A, 4F, 4G, 4H, 4K, 4L, 4M, 4N, 4S, 4T, 4W, 5K, 47, 54, 59, 72, 7A, 7J, 7W, 7X, 82, 8P, 8R, E2, E5, K1, M3, M7, P5, P7, P9
Aged	10, 14, 16, 17, 1E, 1H
Aged/Dual Eligible	10, 14, 16, 17, 1E, 1H, 1X, 1Y
Disabled	20, 24, 26, 27, 36, 60, 64, 66, 67, 2E, 2H, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6V, 6W, 6X, 6Y
Long Term Care/ Full Dual Eligible	13, 23, 53, 63
Long Term Care/ Non-Full Dual Eligible	13, 23, 53, 63
Breast and Cervical Cancer Treatment Program (BCCTP)	0M, 0N, 0P, 0R, 0T, 0U, 0W
Adult Expansion	L1, M1, 7U

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention could reasonably be expected to result in any of the following:

- A. Placing the patient's health (or in the case of pregnant woman, the health of the woman or unborn child) in serious jeopardy.
- B. Serious impairment to bodily function.
- C. Serious dysfunction of any bodily organ or part.

Emergency 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

**Exhibit E, Attachment 1
DEFINITIONS**

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 in with Contractor during the date of service. It includes, but is not limited to, all services for which Contractor incurred any financial liability.

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.

Enhanced Case Management (ECM) means a service for Members who received ADHC services from July 1, 2011 through February 29, 2012 but were deemed ineligible for CBAS, consisting of Complex Case Management and Person-Centered Planning services including the coordination of eligible Medi-Cal beneficiaries' individual needs for the full array of necessary long-term services and supports including medical, social, educational, and other services, whether covered or not under the Medicaid program, and periodic in-person consultation with the Member and/or the Member's designees.

Enrollment means the process by which an Eligible Beneficiary becomes a Member of the Contractor's 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.

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;

**Exhibit E, Attachment 1
DEFINITIONS**

- 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 or its Subcontractors 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.

Federal Financial Participation (FFP) means Federal expenditures provided to match proper State expenditures made under approved State Medicaid plans.

Federally Qualified Health Center (FQHC) means an entity defined in Section 1905 of the Social Security Act (42 United States Code 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 §300e).

**Exhibit E, Attachment 1
DEFINITIONS**

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.

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 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.

**Exhibit E, Attachment 1
DEFINITIONS**

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.

Healthcare Effectiveness Data 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.

In-Home Support Services (IHSS) means services provided to Members by the 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.

Individualized Plan of Care (IPC) means a written plan designed to provide a Member determined to be eligible for CBAS with appropriate treatment in accordance with the assessed needs of the Member.

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.

**Exhibit E, Attachment 1
DEFINITIONS**

Knox-Keene Health Care Service Plan Act of 1975 means the law that regulates HMOs and is administrated by the DMHC, commencing with Section 1340, Health and Safety Code.

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, MSSP, 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 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 that produced in any medium, by or on behalf of the Contractor that can reasonably be interpreted as intended to market to Potential Enrollees.

Marketing Representative means a person who is engaged in marketing activities on behalf of the Contractor.

Medi-Cal Eligibility Data System (MEDS) means the automated eligibility information processing system operated by the State which provides on-line access for recipient information, update of recipient eligibility data and on-line printing of immediate need beneficiary identification cards.

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.

**Exhibit E, Attachment 1
DEFINITIONS**

Medi-Cal Only Member means a Member who is eligible for only Medi-Cal and receives CBAS, MSSP, or LTC services from Contractor.

Medi-Cal Provider Manual means the multi-part document published and maintained by DHCS at <https://mcweb.apps.prn.cammiis.medi-cal.ca.gov/publications/manual>. 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 case management, coordination of care, enhanced communication, access and quality measurement services. This definition can change to include all standards as set forth in W&I 14182(c)(13)(B).).

Medical 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 Contractor's Members.

Medically Necessary or Medical Necessity means reasonable and necessary Covered Services to protect life, to prevent illness or disability, alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members receiving MLTSS, Medical Necessity shall be determined in accordance with Exhibit A, Attachment 21, Provision 7, Covered Services.

When determining the Medical Necessity of Covered Services for a Medi-Cal Member under the age of 21, "Medical Necessity" is expanded to include the standards set forth in 42 USC Section 1396d(r), and W & I Code Section 14132 (v).

Member means any Eligible Beneficiary who is enrolled with Contractor. For the purposes of this Contract, "Enrollee" shall have the same meaning as "Member".

**Exhibit E, Attachment 1
DEFINITIONS**

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.

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.

Multipurpose Senior Service Program (MSSP) means the provision of 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.

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

**Exhibit E, Attachment 1
DEFINITIONS**

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, pharmacy, ancillary Providers, facilities, and any other Providers that Subcontract with Contractor for the delivery of Medi-Cal Covered Services.

Network Provider means a Provider that subcontracts with Contractor for the delivery of Medi-Cal Covered Services.

Newborn Child means a child under the age of one (1) who was 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 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 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.

**Exhibit E, Attachment 1
DEFINITIONS**

Non-Quantitative Treatment Limitation (NQTL) means a limit on the scope or duration of benefits.

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 requirements set forth in 42 CFR 438.404.

Not Report 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 coverage for health related services or entitlements for which an Eligible Beneficiary is eligible under private health plan, any indemnification insurance program, any other State or Federal medical care program, or under other contractual or legal entitlement. The responsibility of an individual or entity, other than Contractor or the Member, for the payment of the reasonable value of all or part of the healthcare benefits provided to a Member. This responsibility may result from a health insurance policy or other contractual agreement or legal obligation, excluding tort liability.

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.

Outpatient Mental Health Services means outpatient services that Contractor will provide for Members with mild to moderate mental health conditions requiring services not covered by the county mental health plan as specialty mental health services, including: individual or group mental health evaluation and treatment (psychotherapy); psychological testing when clinically indicated to evaluate a mental health condition; psychiatric consultation for medication management; and outpatient laboratory, supplies, and supplements.

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

**Exhibit E, Attachment 1
DEFINITIONS**

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.).

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 a highly individualized and ongoing process to develop individualized care plans that focus on a person's abilities and preferences. Person Centered Planning is an integral part of Basic and Complex Case Management and discharge planning.

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 physician group that is designed to motivate physicians or physician groups. Such compensation arrangements may directly or indirectly have the effect of reducing or limiting the services provided to any plan enrollee.

Policy and All Plan Letters means a document that has been dated, numbered, and issued by the Medi-Cal Managed Care Division, and provides clarification of Contractor's obligations pursuant to this Contract, and clarifies mandated changes in State or Federal statutes or regulations, or pursuant to judicial interpretation, but does not add new obligations to the contract.

Post-Payment Recovery means Contractor pays the Provider for the services rendered and then uses all reasonable efforts to recover the cost of the services

**Exhibit E, Attachment 1
DEFINITIONS**

from all liable third parties.

Post-stabilization Services means Covered Services that are provided after a Member is stabilized following an Emergency Medical Condition in order to maintain the stabilized condition or, under the circumstances described in 42 CFR 438.114(e) to improve or resolve the Member's condition.

Potential Enrollee means a Medi-Cal recipient who is subject to mandatory enrollment 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.

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 a 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 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.

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,

**Exhibit E, Attachment 1
DEFINITIONS**

including any complaint, dispute, request for reconsideration or appeal made by a Provider. DHCS considers 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).

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.

Rural Health Clinic (RHC) means an entity defined in Title 22, CCR, Section 51115.5.

Seniors and Persons with Disabilities means Medi-Cal beneficiaries who fall under specific SPD aid codes as defined by the department (See Eligible Beneficiary).

Sensitive Services means those services related to:

- a) Family Planning
- b) Sexually Transmitted Disease (STD)
- c) Human Immunodeficiency Virus testing

Service Area means the county or counties that the Contractor is approved to operate in under the terms of this Contract. A Service Area may have designated ZIP Codes (under the U.S. Postal Service) within a county that are

**Exhibit E, Attachment 1
DEFINITIONS**

approved by DHCS to operate under the terms of this Contract.

Service Authorization Request means request by a Member, or by a provider on behalf of a Member, for the provision of a Covered Service.

Service Location means any location at which a Member obtains any health care service provided by the Contractor under the terms of this Contract.

Skilled Nursing 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".

Specialist means a Physician who has completed advanced education and clinical training in a specific area of medicine or surgery.

Specialty Mental Health Provider means a person or entity who is licensed, certified or otherwise recognized or authorized under State law governing the healing arts to provide Specialty Mental Health Services and who meets the standards for participation in the Medi-Cal program.

Specialty Mental Health Service means:

- A. Rehabilitative services, which includes mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services, and psychiatric health facility services.
- B. Psychiatric inpatient hospital services.
- C. Targeted Case Management.
- D. Psychiatrist services.
- E. Psychologist services.
- F. EPSDT Specialty Mental Health Services.

**Exhibit E, Attachment 1
DEFINITIONS**

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 subcontracted 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.

Subcontract means a written agreement entered into by the Contractor with any of the following:

- A. A Provider of health care services who agrees to furnish Covered Services to Members.
- B. Any other organization or person(s) who agree(s) to perform any administrative function or service for the Contractor specifically related to fulfilling the Contractor's obligations to DHCS under the terms of this Contract.

Subcontractor means an individual or entity who has a Subcontract with Contractor that relates directly or indirectly to the performance of Contractor's obligations under this Contract with DHCS.

Sub-Subcontractor means any party to an agreement with a Subcontractor descending from and subordinate to a Subcontract, which is entered into for the purpose of providing any goods or services connected with the obligations under this Contract.

Supplemental Security Income (SSI) means the program authorized by Title XVI of the Social Security Act for aged, blind, and disabled persons.

**Exhibit E, Attachment 1
DEFINITIONS**

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. Telehealth facilitates the Member's self-management and caregiver support for the Member.

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 and Safety-Net Provider means a Provider of comprehensive primary care and/or acute hospital inpatient services that provides these services to a significant total number of Medi-Cal and charity and/or medically indigent patients in relation to the total number of patients served by the Provider. Examples of Safety-Net Providers include Federally Qualified Health Centers; governmentally operated health systems; community health centers; rural and American Indian Health Service Programs; disproportionate share hospitals; and, public, university, rural, and children's hospitals.

Urgent Care means an episodic physical or mental condition perceived by a managed care beneficiary as serious but not life threatening that disrupts normal activities of daily living and requires assessment by a health care provider and if necessary, treatment within 24-72 hours.

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.

**Exhibit E, Attachment 1
DEFINITIONS**

Working day (s) mean State 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 15. Sanctions, the parties agree that any remedies for DHCS' or Contractor's non-compliance with laws not expressly incorporated into this Contract, or any covenants judicially implied to be part of this Contract, shall not include money damages, but may include equitable remedies such as injunctive relief or specific performance. This Contract is the product of mutual negotiation, and if any ambiguities should arise in the interpretation of this Contract, both parties shall be deemed authors of this Contract.

B. Any provision of this Contract that is in conflict with current or future applicable Federal or State laws or regulations is hereby amended to conform to the provisions of those laws and regulations. Such amendment of the Contract shall be effective on the effective date of the statutes or regulations necessitating it, and shall be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

Such amendment shall constitute grounds for termination of this Contract in accordance with the procedures and provisions of Provision 13, Paragraph C. Termination - Contractor. 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 PLs and APLs issued by DHCS. Final PLs and APLs can be viewed at:

www.dhcs.ca.gov/formsandpubs/Pages/MgdCarePlanPolicyLtrs.aspx

**Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS**

- 1) All PLs and APLs issued by DHCS subsequent to the effective date and during the term of this Contract shall provide clarification of Contractor's obligations pursuant to this Contract, and/or inform and provide clarification to Contractor regarding mandated changes in State or federal law or regulations, or pursuant to judicial interpretation, but shall not add new obligations to the Contract.
 - 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, any amendments, and all documents incorporated by reference shall constitute the entire agreement between the parties. No oral representations shall be binding on either party unless such representations are reduced to writing and made an amendment to the Contract consistent with Exhibit E, Attachment 2, Provision 3.

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

**Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS**

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. Such changes shall be implemented by amendment to this Contract in accordance with Exhibit E, Attachment 2, Provision 3.

5. Delegation of Authority

DHCS intends to implement this Contract through a single administrator, called the "Contracting Officer." DHCS will designate the Contracting Officer. The Contracting Officer, on behalf of DHCS, will make all determinations and take all actions as are appropriate under this Contract, subject to the limitations of applicable Federal and State laws and regulations.

Contractor will designate a single administrator, called the "Contractor's Representative." Contractor shall designate the Contractor's Representative in writing and shall notify the Contracting Officer in accordance with Exhibit E, Attachment 2, Provision 10. Notices. The Contractor's Representative will make all determinations and take all actions as are appropriate to implement this Contract, subject to the limitations of applicable Federal and State laws and regulations. The Contractor's Representative may delegate his/her authority to act to an authorized representative through written notice to the Contracting Officer. The Contractor's Representative, or authorized representative if applicable, will be empowered to legally bind the Contractor to all agreements reached with DHCS.

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 County Organized Health System Program administered in this Contract or coverage for such benefits, or the eligibility of the beneficiaries or Providers to participate in the County Organized Health System Program reside with the State.

Sole authority to establish or interpret policy and its application related to the above areas will reside with the State.

The Contractor may not make any limitations, exclusions, or changes in benefits or benefit coverage; any changes in definition or interpretation of benefits; or any changes in the administration of the Contract related to the scope of benefits, allowable coverage for those benefits, or eligibility of beneficiaries or Providers to participate in the program, without an amendment to this Contract, in accordance with Exhibit E, Attachment 2, Provision 3.

**Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS**

7. Fulfillment of Obligations

Contractor shall comply with all applicable requirements specified in Federal and State laws and regulations. No covenant, condition, duty, obligation, or undertaking continued or made a part of this Contract will be waived except by an amendment to this Contract in accordance with Exhibit E, Attachment 2, Provision 3. 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. Data Certifications

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;

**Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS**

- 6) Contractor's information on ownership and control, including its Subcontractors;
 - 7) The annual report of Overpayment recoveries as required in 42 CFR 438.608(d)(3); and
 - 8) 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. With respect to any report, invoice, record, papers, documents, books of account, or other Contract required data submitted, pursuant to the requirements of this Contract, the Contractor's Representative or his/her designee will certify, under penalty of perjury, that the report, invoice, record, papers, documents, books of account or other Contract required data is current, accurate, complete and in full 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

All notices to be given under this Contract will be in writing and will be deemed to have been given when received by DHCS or the Contractor:

Department of Health Care Services	Plan Name
Managed Care Operations Division	Attn:
MS 4407, P.O. Box 997413	Address
Sacramento, CA 95899-7413	
Attn: Contracting Officer	

11. Term

- A. The Contract will become effective [Month] XX, 20XX, and will continue in full force and effect through [Month] XX, 20XX 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 9 Federal Contract Funds.

**Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS**

- 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.
- 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, 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, 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:

_____ County.

13. Contract Extension

DHCS will have the exclusive option to offer to extend the term of the Contract for any Service Area during the last 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. 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 thirty calendar days of the receipt of the notice from DHCS.

14. Termination

**Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS**

In addition to Exhibit C, Provision 7. Termination for Cause, Contractor also agrees to the following:

A. Termination Without Cause - State

DHCS may terminate performance of work under this Contract in whole, or in part, whenever for any reason DHCS determines that the termination is in the best interest of the State. Notification shall be given at least six (6) months prior to the effective date of termination.

B. Termination for Cause - State

- 1) DHCS shall terminate this Contract pursuant to the provisions of Welfare and Institutions Code, Section 14304(a) and Title 22 CCR Section 53352.
- 2) DHCS shall terminate this Contract in the event that 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 et. seq.) by giving written notice to the Contractor.
- 3) In cases where DHCS determines the health and welfare of Members is jeopardized by continuation of the Contract, the Contract will be immediately terminated. Notification will state the effective date of, and the reason for, the termination.
- 4) Except for termination pursuant to Paragraph B, item 3 above, Contractor may dispute the termination decision through the dispute resolution process pursuant to Provision 19, Paragraph B below. 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.

C. Termination – Contractor

Contractor may terminate this Contract, without cause, at any time upon at

**Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS**

least 180 days' advance written notice to DHCS.

D. Termination of Obligations

All obligations to provide Covered Services under this Contract or Contract extension will automatically terminate on the date the Operations Period ends. Termination under this section does not relieve Contractor of its contract termination obligations under Provision 15. Phaseout Requirements, which shall be performed after Contract termination.

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

- A. DHCS shall retain the lesser of an amount equal to ten (10) percent of the last month's Service Area Capitation Payment or \$1,000,000 for the Service Area unless provided otherwise by the Financial Performance Guarantee, from the Capitation Payment of the last month of the Operations Period for the Service Area until all activities required during the Phaseout Period for the Service Area are fully completed to the satisfaction of DHCS, in its sole discretion.

If all Phaseout activities for the Service Area are completed by the end of the Phaseout Period, the withhold will be paid to the Contractor. If the Contractor fails to meet any requirement(s) by the end of the Phaseout Period for the Service Area, DHCS will deduct the costs of the remaining activities from the withhold amount and continue to withhold payment until all activities are completed.

- B. The objective of the Phaseout Period is to ensure that, at the termination of this Contract, the orderly transfer of necessary data and history records is made from the Contractor to DHCS or to a successor Contractor, if applicable. The Contractor shall not provide services to Members during the Phaseout Period.

Ninety calendar days prior to termination or expiration of this Contract and through the Phaseout Period for the Service Area, the Contractor shall assist DHCS in the transition of Members, and in ensuring, to the extent possible, continuity of Member-Provider relationships. In doing this, the Contractor will make available to DHCS copies of Medical Records, patient files, and any other pertinent information, including information

**Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS**

maintained by any Subcontractor, necessary for efficient case management of Members, as determined by the Director. In no circumstances will a Medi-Cal Member be billed for this activity.

- C. Phaseout for this Contract will consist of the processing, payment and monetary reconciliation(s) necessary regarding claims for payment for Covered Services.

Phaseout for the Contract will consist of the completion of all financial and reporting obligations of the Contractor. The Contractor will remain liable for the processing and payment of invoices and other claims for payment for Covered Services and other services provided to Members pursuant to this Contract prior to the expiration or termination. The Contractor will submit to DHCS all reports required under this Contract for the period from the last submitted report through the expiration or termination date.

All data and information provided by the Contractor will be accompanied by letter, signed by the responsible authority, certifying, under penalty of perjury, to the accuracy and completeness of the materials supplied. D. Phaseout Period will commence on the date the Operations Period of the Contract or Contract extension ends. Phaseout related activities are non-payable items.

16. Sanctions

Contractor is subject to sanctions and civil penalties taken pursuant to Welfare and Institutions Code Section 14304 and Title 22 of the CCR Section 53872, however, such sanctions and civil penalties may not exceed the amounts allowable under 42 CFR 438.704 and as stated in APL 18-003. If required by DHCS, Contractor shall ensure Subcontractors cease specified activities, which may include, but are not limited to, referrals, assignment of Members, and reporting, until DHCS determines that Contractor is again in compliance.

- A. In the event DHCS finds Contractor non-compliant with any provisions of this Contract, applicable statutes or regulations, DHCS may impose sanctions provided in Welfare and Institutions Code Section 14304 and Title 22 CCR Section 53872 as modified for purposes of this Contract. Title 22 CCR Section 53872 is so modified as follows:
- 1) Subsection (b)(1) is modified by replacing "Article 2" with "Article 6"
 - 2) Subsection (b)(2) is modified by replacing "Article 3" with "Article 7"
- B. Sanctions for violations of the requirements of Exhibit A, Attachment 4,

**Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS**

regarding QIS shall be governed by Subsection 53872 (b)(4).

- C. For purposes of Sanctions, good cause includes, but is not limited to, the following:
- 1) Three (3) repeated and uncorrected findings of serious deficiencies that have the potential to endanger patient care identified in the medical audits conducted by DHCS.
 - 2) In the case of Exhibit A, Attachment 4, the Contractor consistently fails to achieve the minimum performance, or receives a "Not Reported" designation on an External Accountability Set measure, after implementation of Corrective Actions.
 - 3) A substantial failure to provide Medically Necessary services required under this Contract or law to a Member.
 - 4) Non-compliance with the Contract or applicable federal and State law or regulation.
 - 5) Contractor has accrued claims that have not or will not be recompensed.
- D. Sanctions in the form of denial of payments provided for under this Contract for new Members shall be taken, when and for as long as, payment for those Members is denied by CMS under 42 CFR 438.730.
- E. The Director shall have the power and authority to take one or more of the following sanctions against Contractor for noncompliance:
- 1) Appointment of temporary management if Contractor has repeatedly failed to meet the contractual requirements or applicable Federal and State law or regulation. Contractor cannot delay appointment of temporary management to provide a hearing before appointment. Temporary management will not be terminated until DHCS determines that Contractor's sanctioned behavior will not recur.
 - 2) Suspension of all new enrollment, including default enrollment, or marketing activities after the effective date of the sanction;
 - 3) Require Contractor to temporarily suspend or terminate personnel or Subcontractors.

**Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS**

- 4) Take other appropriate action as determined necessary by DHCS.

17. Amounts of Civil Money Penalties

A. General rule.

- 1) The limit on, or the maximum civil money penalty DHCS may impose varies depending on the nature of the Contractor's action or failure to act, as provided in this section.

B. Specific Limits.

- 1) The limit is \$25,000 for each determination under the following paragraphs of 42 CFR 438.700:
- a) Paragraph (b)(1) (Failure to provide services): Fails substantially to provide medical necessary services that the Contractor is required to provide, under law or under its contract with DHCS, to an enrollee covered under the contract.
 - b) Paragraph (b)(5) (Misrepresentation or false statements to enrollees, potential enrollees, or health care providers): Misrepresents or falsifies information that it furnishes to an enrollee, potential enrollee, or health care provider.
 - c) Paragraph (b)(6) (Physician Incentive Plan violations): Fails to comply with the requirements for physician incentive plans, as set forth (for Medicare) in 42 CFR 422.208 and 42 CFR 422.210.
 - d) Paragraph (c) (Marketing violations): has distributed directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by the State or that contain false or materially misleading information.
- 2) The limit is \$100,000 for each determination under the following paragraphs of 42 CFR 438.700:
- a) Paragraph (b)(3) (discrimination): Acts to discriminate among enrollees on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to reenroll a beneficiary, except as permitted under the Medicaid program, or any practice that

**Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS**

would reasonably be expected to discourage enrollment by beneficiaries whose medical condition or history indicates probably need for substantial future medical services.

- b) Paragraph (b)(4) (Misrepresentation or false statements to CMS or DHCS): Misrepresents or falsifies information that is furnishes to CMS or to DHCS.
- c) The limit is \$15,000 for each beneficiary DHCS determines was not enrolled because of a discriminatory practice under paragraph (b)(3) of 42 CFR 438.700. (This is subject to the overall limit of \$100,000 under paragraph (b)(2) of 42 CFR 438.700).

C. Specific Amount.

- 1) For premiums or charges in excess of the amounts permitted under the Medi-Cal program, the maximum amount of the penalty is \$25,000 or double the amount of the excess charges, whichever is greater. DHCS must deduct from the penalty the amount of the overcharge and return it to the affected enrollees.

18. Due Process: Notice of Proposed Sanction and Effective Date

A. Notice of Proposed Sanction to Contractor

- 1) Except as provided in 42 CFR 438.706(c), before imposing any of the intermediate sanctions specified in Exhibit E, Attachment 2, Provisions 16 and 17 of this Contract, DHCS must give the affected Contractor timely written notice that explains the following:
 - a) The basis and nature of the proposed sanction;
 - b) The corrective action required of Contractor that may be taken to avoid the sanction within a stated time limit.
- 2) The notice shall allow Contractor at least 15 calendar days from the date it receives the notice to provide evidence that it has not acted or failed to act in the manner that is the basis for the recommended sanction. DHCS may extend the 15 calendar day period if:
 - a) Contractor submits a written request that includes a credible explanation of why it needs additional time;
 - b) The request is received by DHCS before the end of the

**Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS**

stated time period; and

- c) DHCS has not determined that Contractor's conduct poses a threat to enrollee health or safety.
- 3) If Contractor submits a timely response to the notice of proposed sanction, DHCS shall:
 - a) Conduct an informal reconsideration that includes review of the evidence by a DHCS official who did not participate in the original sanction recommendation; and
 - b) Provide Contractor with a written decision setting forth the factual and legal basis for the decision; and
 - c) Forward the decision to CMS.

B. Notice to CMS.

- 1) DHCS must give the CMS Regional Office written notice whenever it imposes or lifts a sanction for one of the violations listed in Exhibit E, Attachment 2, Provisions 16 or 17.
- 2) DHCS' decision becomes CMS' decision unless CMS reverses or modifies the decision within 15 days from receipt by CMS.
- 3) If CMS reverses or modifies the State agency decision, DHCS must send a copy of CMS' decision to Contractor.

C. Effective Date.

- 1) If Contractor does not seek reconsideration, a sanction is effective 15 days after the date the Contractor is notified under Exhibit E, Attachment 2, Provision 16 of the decision to impose the sanction.
- 2) If Contractor seeks reconsideration, the sanction is effective or vacated on the date specified in CMS' reconsideration notice.

19. Disputes

In addition to Exhibit C, Provision 6. Disputes, Contractor also agrees to the following:

This Disputes section will be used by the Contractor as the means of seeking resolution of disputes on contractual issues.

**Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS**

Filing a dispute will not preclude DHCS from recouping the value of the amount in dispute from Contractor or from offsetting this amount from subsequent Capitation Payment(s). If the amount to be recouped exceeds 25 percent of the Capitation Payment, amounts of up to 25 percent will be withheld from successive Capitation Payments until the amount in dispute is fully recouped.

A. Disputes Resolution by Negotiation

DHCS and Contractor agree to try to resolve all contractual issues by negotiation and mutual agreement at the Contracting Officer level without litigation. The parties recognize that the implementation of this policy depends on open-mindedness, and the need for both sides to present adequate supporting information on matters in question.

B. Notification of Dispute

Within 15 calendar days of the date the dispute concerning performance of this Contract arises or otherwise becomes known to the Contractor, the Contractor will notify the Contracting Officer in writing of the dispute, describing the conduct (including actions, inactions, and written or oral communications) which it is disputing.

The Contractor's notification will state, on the basis of the most accurate information then available to the Contractor, the following:

- 1) That it is a dispute pursuant to this section.
- 2) The date, nature, and circumstances of the conduct which is subject of the dispute.
- 3) The names, phone numbers, function, and activity of each Contractor, Subcontractor, DHCS/State official or employee involved in or knowledgeable about the conduct.
- 4) The identification of any documents and the substances of any oral communications involved in the conduct. Copies of all identified documents will be attached.
- 5) The reason the Contractor is disputing the conduct.
- 6) The cost impact to the Contractor directly attributable to the alleged conduct, if any.

**Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS**

- 7) The Contractor's desired remedy.

The required documentation, including cost impact data, will be carefully prepared and submitted with substantiating documentation by the Contractor. This documentation will serve as the basis for any subsequent appeal.

Following submission of the required notification, with supporting documentation, the Contractor will comply with the requirements of Title 22 CCR Section 53851(d) and diligently continue performance of this Contract, including matters identified in the Notification of Dispute, to the maximum extent possible.

C. Contracting Officer's or Alternate Dispute Officer's Decision

Pursuant to a request by Contractor, the Contracting Officer may provide for a dispute to be decided by an alternate dispute officer designated by DHCS, who is not the Contracting Officer and is not directly involved in the Medi-Cal Managed Care Program.

Any disputes concerning performance of this Contract shall be decided by the Contracting Officer or the alternate dispute officer in a written decision stating the factual basis for the decision. Within 30 calendar days of receipt of a Notification of Dispute, the Contracting Officer or the alternate dispute officer, shall either:

- 1) Find in favor of Contractor, in which case the Contracting Officer or alternate dispute officer may:
 - a) Countermand the earlier conduct which caused Contractor to file a dispute; or
 - b) Reaffirm the conduct and, if there is a cost impact sufficient to constitute a change in obligations pursuant to the payment provisions contained in Exhibit B, direct DHCS to comply with that Exhibit.

Or,

- 2) Deny Contractor's dispute and, where necessary, direct the manner of future performance; or
- 3) Request additional substantiating documentation in the event the information in Contractor's notification is inadequate to permit a

**Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS**

decision to be made under 1) or 2) above, and shall advise Contractor as to what additional information is required, and establish how that information shall be furnished. Contractor shall have 30 calendar days to respond to the Contracting Officer's or alternate dispute officer's request for further information. Upon receipt of this additional requested information, the Contracting Officer or alternate dispute officer shall have 30 calendar days to respond with a decision. Failure to supply additional information required by the Contracting Officer or alternate dispute officer within the time period specified above shall constitute waiver by Contractor of all claims in accordance with Paragraph F. Waiver of Claims below. A copy of the decision shall be served on Contractor.

D. Contractor-level Appeal of Contracting Officer's or Alternate Dispute Officer's Decision

Contractor shall have 30 calendar days following the receipt of the decision to file an appeal of the decision to the Director. All appeals shall be governed by Health and Safety Code Section 100171, except for those provisions of Section 100171(d)(1) relating to accusations, statements of issues, statement to respondent, and notice of defense. All appeals shall be in writing and shall be filed with DHCS' Office of Administrative Hearings and Appeals. An appeal shall be deemed filed on the date it is received by the Office of Administrative Hearings and Appeals. An appeal shall specifically set forth each issue in dispute, and include Contractor's contentions as to those issues. However, Contractor's appeal shall be limited to those issues raised in its Notification of Dispute filed pursuant to Paragraph B. Notification of Dispute above. Failure to timely appeal the decision shall constitute a waiver by Contractor of all claims arising out of that conduct, in accordance with Paragraph F. Waiver of Claims. Contractor shall exhaust all procedures provided for in this Provision 19. Disputes, prior to initiating any other action to enforce this Contract.

E. Contractor Duty to Perform

Pending final determination of any dispute hereunder, Contractor shall comply with the requirements of Title 22 CCR Section 53851 (d) and proceed diligently with the performance of this Contract and in accordance with the Contracting Officer's or alternate dispute officer's decision.

If pursuant to an appeal under Paragraph D, Appeal of Contracting Officer's or Alternate Dispute Officer's Decision above, the Contracting Officer's or alternate dispute officer's decision is reversed, the effect of the decision pursuant to Paragraph D. shall be retroactive to the date of the

**Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS**

Contracting Officer's or alternative dispute resolution decision, and Contractor shall promptly receive any benefits of such decision. DHCS shall not pay interest on any amounts paid pursuant to a Contracting Officer's or alternative dispute resolution decision or any appeal of such decision, or any subsequent court decision or court order regarding the subject matter of the Notification of Dispute.

F. Waiver of Claims

If Contractor fails to submit a Notification of Dispute, supporting and substantiating documentation, any additionally required information, or an appeal of the Contracting Officer's or alternate dispute officer's decision, in the manner and within the time specified in this Provision 19. Disputes, that failure shall constitute a waiver by Contractor of all claims arising out of that conduct, 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, 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 10 years from the final date of the Contract period or from the date of completion of any audit, whichever is later.

The Contractor will maintain such records and documents necessary to disclose how the 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 the 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.

**Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS**

B. Records Retention

Notwithstanding any other records retention time period set forth in this Contract, Contractor and all of its Subcontractors 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:
 - 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 to be compliant, as applicable, with 42 CFR 438.3(u)

21. Inspection Rights

In addition to Exhibit D (F), Provision 8. Site Inspection, Contractor also agrees to the following:

Through the end of the records retention period specified in Provision 20. Audit, Paragraph B. Records Retention, 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, Department of Managed Health Care (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 and Subcontractors pertaining to these services at any time, pursuant to 42 CFR 438.3(h).

**Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS**

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, Subcontracts, information systems and procedures, and any other documentation pertaining to medical and non-medical services rendered to Members. Upon request, through the end of the records retention period specified in Provision 20. Audit, Paragraph B. Records Retention, Contractor shall furnish any record, or copy of it, to DHCS or any other entity listed in this section, at Contractor's sole expense.

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 at any time.

A. Facility Inspections

DHCS shall conduct unannounced validation reviews of the Contractor's Primary Care or other service sites, selected at DHCS' discretion, to verify compliance of these sites with State and federal regulations and Contract requirements.

B. Access Requirements and State's Right To Monitor

Authorized State and federal agencies will have the right to monitor all aspects of the Contractor's operation for compliance with the provisions of this Contract and applicable Federal and State laws and regulations. Such monitoring activities will include, but are not limited to, inspection and auditing of Contractor, Subcontractor, and Provider facilities, management systems and procedures, and books and records as the Director deems appropriate, at any time, 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 the Contractor. This will include the MIS operations site or such other place where duties under the Contract are being performed.

Staff designated by authorized State agencies will have access to all security areas and the Contractor will provide, and will require any and all of its Subcontractors to provide, reasonable facilities, cooperation and assistance to State representative(s) in the performance of their duties. Access will be undertaken in such a manner as to not unduly delay the work of the Contractor and/or the Subcontractor(s).

**Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS**

22. Confidentiality of Information

In addition to Exhibit D (F), Provision 13. Confidentiality of Information and Exhibit G, Health Insurance Portability and Accountability Act, 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 Title 42 CFR Section 431.300 et seq., Welfare and Institutions 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 law pertaining to the release of this type of information. Contractor is not required to report requests for Medical Records made in accordance with applicable law.

- B. With respect to any identifiable information concerning a Member under this Contract that is obtained by the Contractor or its Subcontractors, the Contractor: (1) will not use any such information for any purpose other than carrying out the express terms of this Contract, (2) will promptly transmit to DHCS all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law, (3) will not disclose except as otherwise specifically permitted by this Contract, any such information to any party other than DHCS without DHCS' prior written authorization specifying that the information is releasable under Title 42 CFR Section 431.300 et seq., Welfare and Institutions Code Section 14100.2, and regulations adopted there under, and (4) will, at the termination of this Contract, return all such information to DHCS or maintain such information according to written procedures sent to the Contractor by DHCS for this purpose.

23. Pilot Projects

DHCS may establish pilot projects to test alternative managed care models tailored to suit the needs of populations with special health care needs. The operation of these pilot projects may result in the disenrollment of Members that participate. Implementation of a pilot project may affect the Contractor's obligations under this Contract. Any changes in the obligations of the Contractor

**Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS**

that are necessary for the operation of a pilot project in the Contractor's Service Area will be implemented through a Contract amendment, in accordance with Exhibit E, Attachment 2, Provision 3.

24. Cost Avoidance and Post-Payment Recovery of Other Health Coverage Sources (OHCS)

- A. Contractor shall Cost Avoid or make a Post-Payment Recovery for the reasonable value of services paid for by Contractor and rendered to a Member whenever a Member's OHCS covers the same services, either fully or partially. However, in no event shall Contractor Cost Avoid or seek Post-Payment Recovery for the reasonable value of services from a Third-Party Tort Liability (TPTL) action or make a claim against the estates of deceased Members.
- B. Contractor retains all OHCS monies recovered by Contractor.
- C. Contractor shall coordinate benefits with other coverage programs or entitlements, recognizing the OHCS as primary and the Medi-Cal program as the payor of last resort.
- D. Cost Avoidance
 - 1) If Contractor reimburses the Provider on a fee-for-service basis, Contractor shall not pay claims for services provided to a Member whose Medi-Cal eligibility record indicates third party coverage, designated by a Other Health Coverage (OHC) code or Medicare coverage, without proof that the Provider has first exhausted all sources of other payments. Contractor shall have written procedures implementing this requirement.
 - 2) Proof of third party billing is not required prior to payment for services provided to Members with OHC codes A or N.
- E. Post-Payment Recovery
 - 1) If Contractor reimburses the Provider on a fee-for-service basis, Contractor shall pay the Provider's claim and then seek to recover the cost of the claim by billing the OHCS:
 - a) For services provided to Members with OHC code A;
 - b) For services defined by DHCS as prenatal or preventive pediatric services; or

**Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS**

- c) In child-support enforcement cases, identifiable by Contractor. If Contractor does not have access to sufficient information to determine whether or not the OHC is the result of a child enforcement case, Contractor shall follow the procedures for Cost Avoidance.
- 2) In instances where Contractor does not reimburse the Provider on a fee-for-service basis, Contractor shall pay for services provided to a Member whose eligibility record indicates third party coverage, designated by an OHC code or Medicare coverage, and then shall bill the OHCS for the cost of actual services rendered.
- 3) Contractor shall also bill the OHCS for the cost of services provided to Members who are retroactively identified by Contractor or DHCS as having OHC.
- 4) Contractor shall have written procedures implementing the above requirements.

F. Reporting Requirements

- 1) Contractor shall maintain reports that display claims counts and dollar amounts of costs avoided and the amount of Post-Payment Recoveries, by aid category, as well as the amount of outstanding recovery claims (accounts receivable) by age of account. The report shall display separate claim counts and dollar amounts for Medicare Part A and Part B. Reports shall be made available upon DHCS request.
- 2) When Contractor identifies OHC unknown to DHCS, Contractor shall report this information to DHCS within ten (10) calendar days of discovery in automated format as prescribed by DHCS. This information shall be sent to the Department of Health Care Services, Third Party Liability Branch, Other Coverage Unit, P.O. Box 997422, Sacramento, CA 95899-7422.
- 3) Contractor shall demonstrate to DHCS that where Contractor does not Cost Avoid or perform Post-Payment Recovery that the aggregate cost of this activity exceeds the total revenues Contractor projects it would receive from such activity.

25. Third-Party Tort Liability

**Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS**

Contractor shall identify and notify DHCS' Third Party Liability Branch of all instances or cases in which Contractor believes an action by the Medi-Cal Member involving casualty insurance or tort or Workers' Compensation liability of a third party could result in recovery by the Member of funds to which DHCS has lien rights under Article 3.5 (commencing with Section 14124.70), Part 3, Division 9, Welfare and Institutions Code. Contractor shall make no claim for recovery of the value of Covered Services rendered to a Member in such cases or instances and such case or instance shall be referred to DHCS' Third Party Liability Branch within ten (10) calendar days of discovery. To assist DHCS in exercising its responsibility for such recoveries, Contractor shall meet the following requirements:

- A. If DHCS requests service information and/or copies of paid invoices/claims for Covered Services to an individual Member, Contractor shall deliver the requested information within 30 calendar days of the request. Service information includes Subcontractor and Out-of-Network Provider data. The value of the Covered Services shall be calculated as the usual, customary and reasonable charge made to the general public for similar services or the amount paid to subcontracted Providers or Out-of-Network Providers for similar services.
- B. Information to be delivered shall contain the following data items:
 - 1) Member name
 - 2) Full 14 digit Medi-Cal number
 - 3) Social Security Number
 - 4) Date of birth
 - 5) Contractor name
 - 6) Provider name (if different from Contractor)
 - 7) Dates of service
 - 8) Diagnosis code and description of illness/injury
 - 9) Procedure code and/or description of services rendered
 - 10) Amount billed by a Subcontractor or Out-of-Network Provider to Contractor (if applicable)
 - 11) Amount paid by other health insurance to Contractor or

**Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS**

Subcontractor (if applicable)

- 12) Amounts and dates of claims paid by Contractor to Subcontractor or Out-of-Network Provider (if applicable)
- 13) Date of denial and reasons for denial of claims (if applicable)
- 14) Date of death (if applicable)
- C. Contractor shall notify DHCS' Third Party Liability Branch in writing, the name, address and telephone number of the person responsible for receiving and complying with requests for mandatory and/or optional at-risk service information.
- D. If Contractor receives any requests from attorneys, insurers, or beneficiaries for copies of bills, Contractor shall refer the request to DHCS' Third Party Liability Branch with the information contained in paragraph B above, and shall provide the name, address and telephone number of the requesting party.
- E. Information submitted to DHCS under this section shall be sent to Department of Health Care Services, Third Party Liability Branch, Recovery Section, P.O. Box 2471, Sacramento, CA 95812-2471.

26. Records Related to Recovery for Litigation

A. Records

Upon request by DHCS, Contractor shall timely gather, preserve and provide to DHCS, in the form and manner specified by DHCS, any information specified by DHCS, subject to any lawful privileges, in Contractor's or its Subcontractors' possession, relating to threatened or pending litigation by or against DHCS. If Contractor asserts that any requested documents are covered by a privilege, Contractor shall: 1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and 2) state the privilege being claimed that supports withholding production of the document. Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against DHCS. Contractor acknowledges that time may be of the essence in responding to such request. Contractor shall use all reasonable efforts to immediately notify DHCS of any subpoenas, document production requests, or requests for records, received by Contractor or its Subcontractors related to this

**Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS**

Contract or Subcontracts entered into under this Contract.

B. Payment for Records

In addition to the payments provided for in Exhibit B, Budget Detail and Payment 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 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 and Abuse

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 Medicaid program, or in reimbursement for services that are not Medically

**Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS**

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 (Title 42 CFR 455.2 and as further defined in Welfare and Institutions Code 14043.1(a).)

Conviction or Convicted means that a judgment of conviction has been entered by a federal, State, or local court, regardless of whether an appeal from that judgment is pending (Title 42 CFR 455.2). This definition also includes the definition of the term “convicted” in Welfare and Institutions Code 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 (Title 42 CFR 455.2; Welfare and Institutions Code 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 438.608 by establishing administrative and management arrangements or procedures, as well as a mandatory compliance plan, which are designed to guard against fraud and abuse. These requirements shall be met through the following:
- 1) Contractor and its Subcontractor, to the extent that its Subcontractor 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

**Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS**

Chief Executive Officer and the Board of Directors.

- 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 to DHCS of all Overpayments identified or recovered, specifying which Overpayments are due to potential fraud.
 - 3) Prompt notification 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 to DHCS when Contractor receives information about a change in a Network Provider's circumstances that may

**Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS**

affect the Network Provider's eligibility to participate in the Medi-Cal managed care program, including the termination of their Provider agreement with Contractor.

- 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 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 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 if known; 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 (1) of three (3) ways:

**Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS**

- a) Email at PIUCases@DHCS.ca.gov;
- b) E-fax at (916) 440-5287; or
- c) U.S. Mail at:

Department of Health Care Services
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 manufactures, 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 is 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 website (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) State working days of removing a suspended, excluded, or terminated provider from its Provider Network and confirm that the provider is no longer receiving payments in connection with the Medicaid program. A removed, suspended, excluded, or terminated provider report can be sent to DHCS in one of three ways:

**Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS**

- a) Email at PIUCases@DHCS.ca.gov;
- b) E-fax at (916) 440-5287; or
- c) U.S. Mail at:

Department of Health Care Services
Managed Care Operations Division
Attention: Chief, Program Integrity Unit
MS 4417
P.O. Box 997413
Sacramento, CA 95899-7413

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 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 discriminate against Members or Eligible Beneficiaries 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, in accordance with Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d, rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulations. For the purpose of this Contract, discriminations on the grounds of race, color, national origin,

**Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS**

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 include, but are 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 anyway 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 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, of the participants to be served.

Contractor shall take affirmative action to ensure that Members are provided Covered Services 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, except where 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 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.

**Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS**

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.

C. Discrimination Complaints

Contractor agrees that copies of all Grievances alleging discrimination against Members or Eligible Beneficiaries 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, will be forwarded to DHCS for review and appropriate action.

30. Federal 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; the Americans with Disabilities Act of 1990, as amended; and Section 1557 of the Patient Protection and Affordable Care Act; and all other laws regarding privacy and confidentiality.

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.

**Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS**

33. 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.

34. 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).

**Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS**

- D. In accordance with 42 CFR 438.608(d)(4), DHCS shall use the results of 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 APL 17-003.

**Exhibit E, Attachment 3
DUTIES OF THE STATE**

1. Payment For Services

Except with respect to the Former Agnews Members defined in Section 4474.5 of Welfare and Institutions Code, DHCS shall pay to Contractor Capitation Payments pursuant to Exhibit B, Budget Detail and Payment Provisions 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.

2. Medical and Other Reviews

DHCS shall conduct reviews in accordance with the provisions of Welfare and Institutions Code Sections 14456 and 14457. DHCS shall have the discretion to accept plan performance reports, audits or reviews conducted by other agencies or accrediting bodies that use standards comparable to those of DHCS. These plan performance reports, audits and reviews may be in lieu of an audit or review conducted by DHCS in order to eliminate duplication of auditing efforts.

3. Enrollment

The parties to this Contract agree that the primary purpose of DHCS' Medi-Cal managed care system is to improve quality and access to care for Medi-Cal beneficiaries. The parties acknowledge that the Medi-Cal eligibility process and the managed care enrollment system are dynamic and complex programs. The parties also acknowledge that it is impractical to ensure that every beneficiary eligible for enrollment in the Contractor's plan will be enrolled in a timely manner. 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. The parties agree that to accomplish this goal it is necessary to be reasonably flexible with regard to the enrollment process.

4. Enrollment and Disenrollment Processing

Each month, on or before the third calendar day following the date that the file of Medi-Cal Eligible Beneficiaries closes, DHCS will make available electronically to Contractor, the Fiscal Intermediary Access to MEDS (FAME) file which lists all beneficiaries who will be a Member of Contractor's plan in the current month and/or any plan Member during the previous 12 months. In addition, DHCS shall make available electronically to Contractor a daily extract and update of Medi-Cal Eligible Beneficiaries reflecting any current plan Member, and/or any plan Member during the previous 12 months, whose FAME file information was updated that day. DHCS shall also process all Member disenrollments.

**Exhibit E, Attachment 3
DUTIES OF THE STATE**

5. Approval Process for Submitted Materials During Operations

For materials required to be submitted during the Operations Period of this contract, DHCS shall make all reasonable efforts to review such materials within 60 calendar days of receipt. At the conclusion of the review, DHCS will notify Contractor whether the materials are approved or why the materials are not approved.

If DHCS does not complete its review of submitted material within 60 calendar days of receipt, Contractor may elect to implement or use the material at Contractor's sole risk and subject to possible subsequent disapproval by DHCS. This provision shall not be construed to imply DHCS approval of any material that has not received written DHCS approval. This provision shall not apply to Subcontracts or sub-subcontracts subject to DHCS approval in accordance with Exhibit A, Attachment 6, Provision 13, Paragraphs C and D.

6. Risk Limitation

Except as provided in Exhibit B, Provision 12. Recovery of Capitation Payments there will be no risk limitation and Contractor will have full financial liability to provide Medically Necessary Covered Services to Members.

7. Member Notification

DHCS shall notify Members of their health care benefits and options available upon termination or expiration of this Contract.

8. 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, 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

**Exhibit E, Attachment 3
DUTIES OF THE STATE**

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).
 - 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, 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.

The print out of this page should be discarded. The electronic version of this document page had “hidden” text with instructions to the user. Click on the “Show/Hide” or “¶” button to see the hidden text.

DO NOT DELETE THIS PAGE ELECTRONICALLY – It is coded to be “hidden” and the text will not print. A page with only the above first Paragraph will be in this place when you print this document, so **remove it when printing your final contract and place Exhibit F here.**

Exhibit G
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

I. Recitals

- A. This Contract (Agreement) has been determined to constitute a business associate relationship under the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ('the HITECH Act'), 42 U.S.C. section 17921 et seq., and their implementing privacy and security regulations at 45 CFR Parts 160 and 164 ("the HIPAA regulations").
- B. The Department of Health Care Services ("DHCS") wishes to disclose to Business Associate certain information pursuant to the terms of this Agreement, some of which may constitute Protected Health Information ("PHI"), including protected health information in electronic media ("ePHI"), under federal law, and personal information ("PI") under state law.
- C. As set forth in this Agreement, Contractor, here and after, is the Business Associate of DHCS acting on DHCS' behalf and provides services, arranges, performs or assists in the performance of functions or activities on behalf of DHCS and creates, receives, maintains, transmits, uses or discloses PHI and PI. DHCS and Business Associate are each a party to this Agreement and are collectively referred to as the "parties."
- D. The purpose of this Addendum is to protect the privacy and security of the PHI and PI that may be created, received, maintained, transmitted, used or disclosed pursuant to this Agreement, and to comply with certain standards and requirements of HIPAA, the HITECH Act and the HIPAA regulations, including, but not limited to, the requirement that DHCS must enter into a contract containing specific requirements with Contractor prior to the disclosure of PHI to Contractor, as set forth in 45 CFR Parts 160 and 164 and the HITECH Act.
- E. The terms used in this Addendum, but not otherwise defined, shall have the same meanings as those terms have in the HIPAA regulations. Any reference to statutory or regulatory language shall be to such language as in effect or as amended.

II. Definitions

- A. Breach shall have the meaning given to such term under HIPAA, the HITECH Act, and the HIPAA regulations.
- B. Business Associate shall have the meaning given to such term under HIPAA, the HITECH Act, and the HIPAA regulations.

Exhibit G

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

- C. Covered Entity shall have the meaning given to such term under HIPAA, the HITECH Act, and the HIPAA regulations.
- D. Electronic Health Record shall have the meaning given to such term in the HITECH Act, including, but not limited to, 42 U.S.C Section 17921 and implementing regulations.
- E. Electronic Protected Health Information (ePHI) means individually identifiable health information transmitted by electronic media or maintained in electronic media, including but not limited to electronic media as set forth under 45 CFR section 160.103.
- F. Individually Identifiable Health Information means health information, including demographic information collected from an individual, that is created or received by a health care provider, health plan, employer or health care clearinghouse, and relates to the past, present or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, that identifies the individual or where there is a reasonable basis to believe the information can be used to identify the individual, as set forth under 45 CFR section 160.103.
- G. Privacy Rule shall mean the HIPAA Regulation that is found at 45 CRF Parts 160 and 164.
- H. Personal Information shall have the meaning given to such term in California Civil Code section 1798.29.
- I. Protected Health Information means individually identifiable health information that is transmitted by electronic media, maintained in electronic media, or is transmitted or maintained in any other form or medium, as set forth under 45 CFR section 160.103.
- J. Required by law, as set forth under 45 CFR section 164.103, means a mandate contained in law that compels an entity to make a use or disclosure of PHI that is enforceable in a court of law. This includes, but is not limited to, court orders and court-ordered warrants, subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or an administrative body authorized to require the production of information, and a civil or an authorized investigative demand. It also includes Medicare conditions of participation with respect to health care providers participating in the program, and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits.

Exhibit G
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

- K. Secretary means the Secretary of the U.S. Department of Health and Human Services ("HHS") or the Secretary's designee.
- L. Security Incident means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of PHI or PI, or confidential data that is essential to the ongoing operation of the Business Associate's organization and intended for internal use; or interference with system operations in an information system.
- M. Security Rule shall mean the HIPAA regulation that is found at 45 CFR Parts 160 and 164.
- N. Unsecured PHI shall have the meaning given to such term under the HITECH Act, 42 U.S.C. section 17932(h), any guidance issued pursuant to such Act and the HIPAA regulations.

III. Terms of Agreement

A. Permitted Uses and Disclosures of PHI by Business Associate

Permitted Uses and Disclosures. Except as otherwise indicated in this Addendum, Business Associate may use or disclose PHI only to perform functions, activities or services specified in this Agreement, for, or on behalf of DHCS, provided that such use or disclosure would not violate the HIPAA regulations, if done by DHCS. Any such use or disclosure must, to the extent practicable, be limited to the limited data set, as defined in 45 CFR section 164.514(e)(2), or, if needed, to the minimum necessary to accomplish the intended purpose of such use or disclosure, in compliance with the HITECH Act and any guidance issued pursuant to such Act, and the HIPAA regulations.

- 1. ***Specific Use and Disclosure Provisions.*** Except as otherwise indicated in this Addendum, Business Associate may:
 - a. ***Use and disclose for management and administration.*** Use and disclose PHI for the proper management and administration of the Business Associate provided that such disclosures are required by law, or the Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and will be used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware that the confidentiality of the information

Exhibit G
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

has been breached.

- b. **Provision of Data Aggregation Services.*** Use PHI to provide data aggregation services to DHCS. Data aggregation means the combining of PHI created or received by the Business Associate on behalf of DHCS with PHI received by the Business Associate in its capacity as the Business Associate of another covered entity, to permit data analyses that relate to the health care operations of DHCS.

B. Prohibited Uses and Disclosures

1. Business Associate shall not disclose PHI about an individual to a health plan for payment or health care operations purposes if the PHI pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full and the individual requests such restriction, in accordance with 42 U.S.C. section 17935(a) and 45 CFR section 164.522(a).
2. Business Associate shall not directly or indirectly receive remuneration in exchange for PHI, except with the prior written consent of DHCS and as permitted by 42 U.S.C. section 17935(d)(2).

C. Responsibilities of Business Associate

Business Associate agrees:

1. ***Nondisclosure.*** Not to use or disclose Protected Health Information (PHI) other than as permitted or required by this Agreement or as required by law.
2. ***Safeguards.*** To implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI, including electronic PHI, that it creates, receives, maintains, uses or transmits on behalf of DHCS, in compliance with 45 CFR sections 164.308, 164.310 and 164.312, and to prevent use or disclosure of PHI other than as provided for by this Agreement. Business Associate shall implement reasonable and appropriate policies and procedures to comply with the standards, implementation specifications and other requirements of 45 CFR section 164, subpart C, in compliance with 45 CFR section 164.316. Business Associate shall develop and maintain a written information privacy and security program that includes administrative, technical and

Exhibit G
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

physical safeguards appropriate to the size and complexity of the Business Associate's operations and the nature and scope of its activities, and which incorporates the requirements of section 3, Security, below. Business Associate will provide DHCS with its current and updated policies.

3. **Security.** To take any and all steps necessary to ensure the continuous security of all computerized data systems containing PHI and/or PI, and to protect paper documents containing PHI and/or PI. These steps shall include, at a minimum:
 - a. Complying with all of the data system security precautions listed in Attachment A, the Business Associate Data Security Requirements;
 - b. Achieving and maintaining compliance with the HIPAA Security Rule (45 CFR Parts 160 and 164), as necessary in conducting operations on behalf of DHCS under this Agreement;
 - c. Providing a level and scope of security that is at least comparable to the level and scope of security established by the Office of Management and Budget in OMB Circular No. A-130, Appendix III - Security of Federal Automated Information Systems, which sets forth guidelines for automated information systems in Federal agencies; and
 - d. In case of a conflict between any of the security standards contained in any of these enumerated sources of security standards, the most stringent shall apply. The most stringent means that safeguard which provides the highest level of protection to PHI from unauthorized disclosure. Further, Business Associate must comply with changes to these standards that occur after the effective date of this Agreement.

Business Associate shall designate a Security Officer to oversee its data security program who shall be responsible for carrying out the requirements of this section and for communicating on security matters with DHCS.

- D. *Mitigation of Harmful Effects.*** *To mitigate, to the extent practicable, any*

Exhibit G
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate or its subcontractors in violation of the requirements of this Addendum.

E. *Business Associate's Agents and Subcontractors.*

1. To enter into written agreements with any agents, including subcontractors and vendors, to whom Business Associate provides PHI or PI received from or created or received by Business Associate on behalf of DHCS, that impose the same restrictions and conditions on such agents, subcontractors and vendors that apply to Business Associate with respect to such PHI and PI under this Addendum, and that comply with all applicable provisions of HIPAA, the HITECH Act and the HIPAA regulations, including the requirement that any agents, subcontractors or vendors implement reasonable and appropriate administrative, physical, and technical safeguards to protect such PHI and PI. Business Associate shall incorporate, when applicable, the relevant provisions of this Addendum into each subcontract or subaward to such agents, subcontractors and vendors, including the requirement that any security incidents or breaches of unsecured PHI or PI be reported to Business Associate.
2. In accordance with 45 CFR section 164.504(e)(1)(ii), upon Business Associate's knowledge of a material breach or violation by its subcontractor of the agreement between Business Associate and the subcontractor, Business Associate shall:
 - a. Provide an opportunity for the subcontractor to cure the breach or end the violation and terminate the agreement if the subcontractor does not cure the breach or end the violation within the time specified by DHCS; or
 - b. Immediately terminate the agreement if the subcontractor has breached a material term of the agreement and cure is not possible.

F. *Availability of Information to DHCS and Individuals.* To provide access and information:

1. To provide access as DHCS may require, and in the time and manner designated by DHCS (upon reasonable notice and during Business Associate's normal business hours) to PHI in a Designated Record Set, to DHCS (or, as directed by DHCS), to an Individual, in accordance with 45 CFR section 164.524.

Exhibit G
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Designated Record Set means the group of records maintained for DHCS that includes medical, dental and billing records about individuals; enrollment, payment, claims adjudication, and case or medical management systems maintained for DHCS health plans; or those records used to make decisions about individuals on behalf of DHCS. Business Associate shall use the forms and processes developed by DHCS for this purpose and shall respond to requests for access to records transmitted by DHCS within fifteen (15) calendar days of receipt of the request by producing the records or verifying that there are none.

2. If Business Associate maintains an Electronic Health Record with PHI, and an individual requests a copy of such information in an electronic format, Business Associate shall provide such information in an electronic format to enable DHCS to fulfill its obligations under the HITECH Act, including but not limited to, 42 U.S.C. section 17935(e).
3. If Business Associate receives data from DHCS that was provided to DHCS by the Social Security Administration, upon request by DHCS, Business Associate shall provide DHCS with a list of all employees, contractors and agents who have access to the Social Security data, including employees, contractors and agents of its subcontractors and agents.

- G. *Amendment of PHI.*** To make any amendment(s) to PHI that DHCS directs or agrees to pursuant to 45 CFR section 164.526, in the time and manner designated by DHCS.
- H. *Internal Practices.*** To make Business Associate's internal practices, books and records relating to the use and disclosure of PHI received from DHCS, or created or received by Business Associate on behalf of DHCS, available to DHCS or to the Secretary of the U.S. Department of Health and Human Services in a time and manner designated by DHCS or by the Secretary, for purposes of determining DHCS' compliance with the HIPAA regulations. If any information needed for this purpose is in the exclusive possession of any other entity or person and the other entity or person fails or refuses to furnish the information to Business Associate, Business Associate shall so certify to DHCS and shall set forth the efforts it made to obtain the information.
- I. *Documentation of Disclosures.*** To document and make available to DHCS or (at the direction of DHCS) to an Individual such disclosures of PHI, and information related to such disclosures, necessary to respond to

Exhibit G
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

a proper request by the subject Individual for an accounting of disclosures of PHI, in accordance with the HITECH Act and its implementing regulations, including but not limited to 45 CFR section 164.528 and 42 U.S.C. section 17935(c). If Business Associate maintains electronic health records for DHCS as of January 1, 2009, Business Associate must provide an accounting of disclosures, including those disclosures for treatment, payment or health care operations, effective with disclosures on or after January 1, 2014. If Business Associate acquires electronic health records for DHCS after January 1, 2009, Business Associate must provide an accounting of disclosures, including those disclosures for treatment, payment or health care operations, effective with disclosures on or after the date the electronic health record is acquired, or on or after January 1, 2011, whichever date is later. The electronic accounting of disclosures shall be for disclosures during the three years prior to the request for an accounting.

J. Breaches and Security Incidents. During the term of this Agreement, Business Associate agrees to implement reasonable systems for the discovery and prompt reporting of any breach or security incident, and to take the following steps:

1. **Notice to DHCS.** (1) To notify DHCS **immediately by telephone call plus email or fax** upon the discovery of a breach of unsecured PHI or PI in electronic media or in any other media if the PHI or PI was, or is reasonably believed to have been, accessed or acquired by an unauthorized person, or upon the discovery of a suspected security incident that involves data provided to DHCS by the Social Security Administration. (2) To notify DHCS **within 24 hours by email or fax** of the discovery of any suspected security incident, intrusion or unauthorized access, use or disclosure of PHI or PI in violation of this Agreement and this Addendum, or potential loss of confidential data affecting this Agreement. A breach shall be treated as discovered by Business Associate as of the first day on which the breach is known, or by exercising reasonable diligence would have been known, to any person (other than the person committing the breach) who is an employee, officer or other agent of Business Associate.

Notice shall be provided to the DHCS Program Contract Manager, the DHCS Privacy Officer and the DHCS Information Security Officer. If the incident occurs after business hours or on a weekend or holiday and involves electronic PHI, notice shall be provided by calling the DHCS ITSD Service Desk. Notice shall be made using the "DHCS Privacy Incident Report" form, including all information known at the time. Business Associate shall use the most current

Exhibit G
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

version of this form, which is posted on the DHCS Privacy Office website (www.dhcs.ca.gov, then select "Privacy" in the left column and then "Business Use" near the middle of the page) or use this link:

<http://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/DHCSBusinessAssociatesOnly.aspx>

Upon discovery of a breach or suspected security incident, intrusion or unauthorized access, use or disclosure of PHI or PI, Business Associate shall take:

- a. Prompt corrective action to mitigate any risks or damages involved with the breach and to protect the operating environment; and
 - b. Any action pertaining to such unauthorized disclosure required by applicable Federal and State laws and regulations.
2. ***Investigation and Investigation Report.*** To immediately investigate such security incident, breach, or unauthorized access, use or disclosure of PHI or PI. Within 72 hours of the discovery, Business Associate shall submit an updated "DHCS Privacy Incident Report" containing the information marked with an asterisk and all other applicable information listed on the form, to the extent known at that time, to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer:
3. ***Complete Report.*** To provide a complete report of the investigation to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer within ten (10) working days of the discovery of the breach or unauthorized use or disclosure. The report shall be submitted on the "DHCS Privacy Incident Report" form and shall include an assessment of all known factors relevant to a determination of whether a breach occurred under applicable provisions of HIPAA, the HITECH Act, the HIPAA regulations and/or state law. The report shall also include a full, detailed corrective action plan, including information on measures that were taken to halt and/or contain the improper use or disclosure. If DHCS requests information in addition to that listed on the "DHCS Privacy Incident Report" form, Business Associate shall make reasonable efforts to provide DHCS with such information. If necessary, a Supplemental Report may be used to submit revised or additional information after the completed report is submitted, by submitting the revised or

Exhibit G
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

additional information on an updated “DHCS Privacy Incident Report” form. DHCS will review and approve the determination of whether a breach occurred and individual notifications are required, and the corrective action plan.

4. ***Notification of Individuals.*** If the cause of a breach of PHI or PI is attributable to Business Associate or its subcontractors, agents or vendors, Business Associate shall notify individuals of the breach or unauthorized use or disclosure when notification is required under state or federal law and shall pay any costs of such notifications, as well as any costs associated with the breach. The notifications shall comply with the requirements set forth in 42 U.S.C. section 17932 and its implementing regulations, including, but not limited to, the requirement that the notifications be made without unreasonable delay and in no event later than 60 calendar days. The DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer shall approve the time, manner and content of any such notifications and their review and approval must be obtained before the notifications are made.
5. ***Responsibility for Reporting of Breaches.*** If the cause of a breach of PHI or PI is attributable to Business Associate or its agents, subcontractors or vendors, Business Associate is responsible for all required reporting of the breach as specified in 42 U.S.C. section 17932 and its implementing regulations, including notification to media outlets and to the Secretary. If a breach of unsecured PHI involves more than 500 residents of the State of California or its jurisdiction, Business Associate shall notify the Secretary of the breach immediately upon discovery of the breach. If Business Associate has reason to believe that duplicate reporting of the same breach or incident may occur because its subcontractors, agents or vendors may report the breach or incident to DHCS in addition to Business Associate, Business Associate shall notify DHCS, and DHCS and Business Associate may take appropriate action to prevent duplicate reporting. The breach reporting requirements of this paragraph are in addition to the reporting requirements set forth in subsection 1, above.
6. ***DHCS Contact Information.*** To direct communications to the above referenced DHCS staff, the Contractor shall initiate contact as indicated herein. DHCS reserves the right to make changes to the contact information below by giving written notice to the Contractor. Said changes shall not require an amendment to this Addendum or the Agreement to which it is incorporated.

Exhibit G
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

DHCS Program Contract Manager	DHCS Privacy Officer	DHCS Information Security Officer
See the Scope of Work exhibit for Program Contract Manager information	Privacy Officer c/o: Office of HIPAA Compliance Department of Health Care Services P.O. Box 997413, MS 4722 Sacramento, CA 95899-7413 Toll Free: (866) 866-0602 Telephone: (916) 445-4646 Email: privacyofficer@dhcs.ca.gov Fax: (916) 440-7680	Information Security Officer DHCS Information Security Office P.O. Box 997413, MS 6400 Sacramento, CA 95899-7413 Email: iso@dhcs.ca.gov Fax: (916) 440-5537 Telephone: ITSD Service Desk (916) 440-7000 or (800) 579-0874

K. *Termination of Agreement.* In accordance with Section 13404(b) of the HITECH Act and to the extent required by the HIPAA regulations, if Business Associate knows of a material breach or violation by DHCS of this Addendum, it shall take the following steps:

1. Provide an opportunity for DHCS to cure the breach or end the violation and terminate the Agreement if DHCS does not cure the breach or end the violation within the time specified by Business Associate; or
2. Immediately terminate the Agreement if DHCS has breached a material term of the Addendum and cure is not possible.

L. *Due Diligence.* Business Associate shall exercise due diligence and shall take reasonable steps to ensure that it remains in compliance with this Addendum and is in compliance with applicable provisions of HIPAA, the HITECH Act and the HIPAA regulations, and that its agents, subcontractors and vendors are in compliance with their obligations as required by this Addendum.

M. *Sanctions and/or Penalties.* Business Associate understands that a failure to comply with the provisions of HIPAA, the HITECH Act and the HIPAA regulations that are applicable to Business Associate may result in the imposition of sanctions and/or penalties on Business Associate under HIPAA, the HITECH Act and the HIPAA regulations.

IV. Obligations of DHCS

Exhibit G
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

DHCS agrees to:

- A. *Notice of Privacy Practices.*** Provide Business Associate with the Notice of Privacy Practices that DHCS produces in accordance with 45 CFR section 164.520, as well as any changes to such notice. Visit the DHCS Privacy Office to view the most current Notice of Privacy Practices at: <http://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/default.aspx> or the DHCS website at www.dhcs.ca.gov (select "Privacy in the left column and "Notice of Privacy Practices" on the right side of the page).
- B. *Permission by Individuals for Use and Disclosure of PHI.*** Provide the Business Associate with any changes in, or revocation of, permission by an Individual to use or disclose PHI, if such changes affect the Business Associate's permitted or required uses and disclosures.
- C. *Notification of Restrictions.*** Notify the Business Associate of any restriction to the use or disclosure of PHI that DHCS has agreed to in accordance with 45 CFR section 164.522, to the extent that such restriction may affect the Business Associate's use or disclosure of PHI.
- D. *Requests Conflicting with HIPAA Rules.*** Not request the Business Associate to use or disclose PHI in any manner that would not be permissible under the HIPAA regulations if done by DHCS.

V. Audits, Inspection and Enforcement

- A.** From time to time, DHCS may inspect the facilities, systems, books and records of Business Associate to monitor compliance with this Agreement and this Addendum. Business Associate shall promptly remedy any violation of any provision of this Addendum and shall certify the same to the DHCS Privacy Officer in writing. The fact that DHCS inspects, or fails to inspect, or has the right to inspect, Business Associate's facilities, systems and procedures does not relieve Business Associate of its responsibility to comply with this Addendum, nor does DHCS':
 - 1. Failure to detect or
 - 2. Detection, but failure to notify Business Associate or require Business Associate's remediation of any unsatisfactory practices constitute acceptance of such practice or a waiver of DHCS' enforcement rights under this Agreement and this Addendum.
- B.** If Business Associate is the subject of an audit, compliance review, or complaint investigation by the Secretary or the Office of Civil Rights, U.S. Department of Health and Human Services, that is related to the

Exhibit G
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

performance of its obligations pursuant to this HIPAA Business Associate Addendum, Business Associate shall notify DHCS and provide DHCS with a copy of any PHI or PI that Business Associate provides to the Secretary or the Office of Civil Rights concurrently with providing such PHI or PI to the Secretary. Business Associate is responsible for any civil penalties assessed due to an audit or investigation of Business Associate, in accordance with 42 U.S.C. section 17934(c).

VI. Termination

- A. *Term.*** The Term of this Addendum shall commence as of the effective date of this Addendum and shall extend beyond the termination of the contract and shall terminate when all the PHI provided by DHCS to Business Associate, or created or received by Business Associate on behalf of DHCS, is destroyed or returned to DHCS, in accordance with 45 CFR 164.504(e)(2)(ii)(I).
- B. *Termination for Cause.*** In accordance with 45 CFR section 164.504(e)(1)(ii), upon DHCS' knowledge of a material breach or violation of this Addendum by Business Associate, DHCS shall:
1. Provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Agreement if Business Associate does not cure the breach or end the violation within the time specified by DHCS; or
 2. Immediately terminate this Agreement if Business Associate has breached a material term of this Addendum and cure is not possible.
- C. *Judicial or Administrative Proceedings.*** Business Associate will notify DHCS if it is named as a defendant in a criminal proceeding for a violation of HIPAA. DHCS may terminate this Agreement if Business Associate is found guilty of a criminal violation of HIPAA. DHCS may terminate this Agreement if a finding or stipulation that the Business Associate has violated any standard or requirement of HIPAA, or other security or privacy laws is made in any administrative or civil proceeding in which the Business Associate is a party or has been joined.
- D. *Effect of Termination.*** Upon termination or expiration of this Agreement for any reason, Business Associate shall return or destroy all PHI received from DHCS (or created or received by Business Associate on behalf of DHCS) that Business Associate still maintains in any form, and shall retain no copies of such PHI. If return or destruction is not feasible, Business Associate shall notify DHCS of the conditions that make the return or

Exhibit G
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

destruction infeasible, and DHCS and Business Associate shall determine the terms and conditions under which Business Associate may retain the PHI. Business Associate shall continue to extend the protections of this Addendum to such PHI, and shall limit further use of such PHI to those purposes that make the return or destruction of such PHI infeasible. This provision shall apply to PHI that is in the possession of subcontractors or agents of Business Associate.

VII. Miscellaneous Provisions

- A. *Disclaimer.*** DHCS makes no warranty or representation that compliance by Business Associate with this Addendum, HIPAA or the HIPAA regulations will be adequate or satisfactory for Business Associate's own purposes or that any information in Business Associate's possession or control, or transmitted or received by Business Associate, is or will be secure from unauthorized use or disclosure. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI.
- B. *Amendment.*** The parties acknowledge that federal and state laws relating to electronic data security and privacy are rapidly evolving and that amendment of this Addendum may be required to provide for procedures to ensure compliance with such developments. The parties specifically agree to take such action as is necessary to implement the standards and requirements of HIPAA, the HITECH Act, the HIPAA regulations and other applicable laws relating to the security or privacy of PHI. Upon DHCS' request, Business Associate agrees to promptly enter into negotiations with DHCS concerning an amendment to this Addendum embodying written assurances consistent with the standards and requirements of HIPAA, the HITECH Act, the HIPAA regulations or other applicable laws. DHCS may terminate this Agreement upon thirty (30) days written notice in the event:
1. Business Associate does not promptly enter into negotiations to amend this Addendum when requested by DHCS pursuant to this Section; or
 2. Business Associate does not enter into an amendment providing assurances regarding the safeguarding of PHI that DHCS in its sole discretion, deems sufficient to satisfy the standards and requirements of HIPAA and the HIPAA regulations.
- C. *Assistance in Litigation or Administrative Proceedings.*** Business Associate shall make itself and any subcontractors, employees or agents assisting Business Associate in the performance of its obligations under

Exhibit G
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

this Agreement, available to DHCS at no cost to DHCS to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against DHCS, its directors, officers or employees based upon claimed violation of HIPAA, the HIPAA regulations or other laws relating to security and privacy, which involves inactions or actions by the Business Associate, except where Business Associate or its subcontractor, employee or agent is a named adverse party.

- D. *No Third-Party Beneficiaries.*** Nothing express or implied in the terms and conditions of this Addendum is intended to confer, nor shall anything herein confer, upon any person other than DHCS or Business Associate and their respective successors or assignees, any rights, remedies, obligations or liabilities whatsoever.
- E. *Interpretation.*** The terms and conditions in this Addendum shall be interpreted as broadly as necessary to implement and comply with HIPAA, the HITECH Act, the HIPAA regulations and applicable state laws. The parties agree that any ambiguity in the terms and conditions of this Addendum shall be resolved in favor of a meaning that complies and is consistent with HIPAA, the HITECH Act and the HIPAA regulations.
- F. *Regulatory References.*** A reference in the terms and conditions of this Addendum to a section in the HIPAA regulations means the section as in effect or as amended.
- G. *Survival.*** The respective rights and obligations of Business Associate under Section VI.D of this Addendum shall survive the termination or expiration of this Agreement.
- H. *No Waiver of Obligations.*** No change, waiver or discharge of any liability or obligation hereunder on any one or more occasions shall be deemed a waiver of performance of any continuing or other obligation, or shall prohibit enforcement of any obligation, on any other occasion.

Exhibit G, Attachment A
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

I. Personnel Controls

- A. *Employee Training.*** All workforce members who assist in the performance of functions or activities on behalf of DHCS, or access or disclose DHCS PHI or PI must complete information privacy and security training, at least annually, at Business Associate's expense. Each workforce member who receives information privacy and security training must sign a certification, indicating the member's name and the date on which the training was completed. These certifications must be retained for a period of six (6) years following contract termination.
- B. *Employee Discipline.*** Appropriate sanctions must be applied against workforce members who fail to comply with privacy policies and procedures or any provisions of these requirements, including termination of employment where appropriate.
- C. *Confidentiality Statement.*** All persons that will be working with DHCS PHI or PI must sign a confidentiality statement that includes, at a minimum, General Use, Security and Privacy Safeguards, Unacceptable Use, and Enforcement Policies. The statement must be signed by the workforce member prior to access to DHCS PHI or PI. The statement must be renewed annually. The Contractor shall retain each person's written confidentiality statement for DHCS inspection for a period of six (6) years following contract termination.
- D. *Background Check.*** Before a member of the workforce may access DHCS PHI or PI, a thorough background check of that worker must be conducted, with evaluation of the results to assure that there is no indication that the worker may present a risk to the security or integrity of confidential data or a risk for theft or misuse of confidential data. The Contractor shall retain each workforce member's background check documentation for a period of three (3) years following contract termination.

II. Technical Security Controls

- A. *Workstation/Laptop encryption.*** All workstations and laptops that process and/or store DHCS PHI or PI must be encrypted using a FIPS 140-2 certified algorithm which is 128bit or higher, such as Advanced Encryption Standard (AES). The encryption solution must be full disk unless approved by the DHCS Information Security Office.
- B. *Server Security.*** Servers containing unencrypted DHCS PHI or PI must have sufficient administrative, physical, and technical controls in place to protect that data, based upon a risk assessment/system security review.

Exhibit G, Attachment A
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

- C. *Minimum Necessary.*** Only the minimum necessary amount of DHCS PHI or PI required to perform necessary business functions may be copied, downloaded, or exported.
- D. *Removable media devices.*** All electronic files that contain DHCS PHI or PI data must be encrypted when stored on any removable media or portable device (i.e. USB thumb drives, floppies, CD/DVD, Blackberry, backup tapes etc.). Encryption must be a FIPS 140-2 certified algorithm which is 128bit or higher, such as AES.
- E. *Antivirus software.*** All workstations, laptops and other systems that process and/or store DHCS PHI or PI must install and actively use comprehensive anti-virus software solution with automatic updates scheduled at least daily.
- F. *Patch Management.*** All workstations, laptops and other systems that process and/or store DHCS PHI or PI must have critical security patches applied, with system reboot if necessary. There must be a documented patch management process which determines installation timeframe based on risk assessment and vendor recommendations. At a maximum, all applicable patches must be installed within 30 days of vendor release.
- G. *User IDs and Password Controls.*** All users must be issued a unique user name for accessing DHCS PHI or PI. Username must be promptly disabled, deleted, or the password changed upon the transfer or termination of an employee with knowledge of the password, at maximum within 24 hours. Passwords are not to be shared. Passwords must be at least eight characters and must be a non-dictionary word. Passwords must not be stored in readable format on the computer. Passwords must be changed every 90 days, preferably every 60 days. Passwords must be changed if revealed or compromised. Passwords must be composed of characters from at least three of the following four groups from the standard keyboard:
- Upper case letters (A-Z)
 - Lower case letters (a-z)
 - Arabic numerals (0-9)
 - Non-alphanumeric characters (punctuation symbols)
- H. *Data Destruction.*** When no longer needed, all DHCS PHI or PI must be wiped using the Gutmann or US Department of Defense (DOD) 5220.22-M (7 Pass) standard, or by degaussing. Media may also be physically destroyed in accordance with NIST Special Publication 800-

Exhibit G, Attachment A
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

88. Other methods require prior written permission of the DHCS Information Security Office.

- I. **System Timeout.** The system providing access to DHCS PHI or PI must provide an automatic timeout, requiring re-authentication of the user session after no more than 20 minutes of inactivity.
- J. **Warning Banners.** All systems providing access to DHCS PHI or PI must display a warning banner stating that data is confidential, systems are logged, and system use is for business purposes only by authorized users. User must be directed to log off the system if they do not agree with these requirements.
- K. **System Logging.** The system must maintain an automated audit trail which can identify the user or system process which initiates a request for DHCS PHI or PI, or which alters DHCS PHI or PI. The audit trail must be date and time stamped, must log both successful and failed accesses, must be read only, and must be restricted to authorized users. If DHCS PHI or PI is stored in a database, database logging functionality must be enabled. Audit trail data must be archived for at least 3 years after occurrence.
- L. **Access Controls.** The system providing access to DHCS PHI or PI must use role based access controls for all user authentications, enforcing the principle of least privilege.
- M. **Transmission encryption.** All data transmissions of DHCS PHI or PI outside the secure internal network must be encrypted using a FIPS 140-2 certified algorithm which is 128bit or higher, such as AES. Encryption can be end to end at the network level, or the data files containing PHI can be encrypted. This requirement pertains to any type of PHI or PI in motion such as website access, file transfer, and E-Mail.
- N. **Intrusion Detection.** All systems involved in accessing, holding, transporting, and protecting DHCS PHI or PI that are accessible via the Internet must be protected by a comprehensive intrusion detection and prevention solution.

III. Audit Controls

- A. **System Security Review.** All systems processing and/or storing DHCS PHI or PI must have at least an annual system risk assessment/security review which provides assurance that administrative, physical, and technical controls are functioning

Exhibit G, Attachment A
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

effectively and providing adequate levels of protection. Reviews should include vulnerability scanning tools.

- B. *Log Reviews.*** All systems processing and/or storing DHCS PHI or PI must have a routine procedure in place to review system logs for unauthorized access.
- C. *Change Control.*** All systems processing and/or storing DHCS PHI or PI must have a documented change control procedure that ensures separation of duties and protects the confidentiality, integrity and availability of data.

IV. Business Continuity / Disaster Recovery Controls

- A. *Emergency Mode Operation Plan.*** Contractor must establish a documented plan to enable continuation of critical business processes and protection of the security of electronic DHCS PHI or PI in the event of an emergency. Emergency means any circumstance or situation that causes normal computer operations to become unavailable for use in performing the work required under this Agreement for more than 24 hours.
- B. *Data Backup Plan.*** Contractor must have established documented procedures to backup DHCS PHI to maintain retrievable exact copies of DHCS PHI or PI. The plan must include a regular schedule for making backups, storing backups offsite, an inventory of backup media, and an estimate of the amount of time needed to restore DHCS PHI or PI should it be lost. At a minimum, the schedule must be a weekly full backup and monthly offsite storage of DHCS data.

V. Paper Document Controls

- A. *Supervision of Data.*** DHCS PHI or PI in paper form shall not be left unattended at any time, unless it is locked in a file cabinet, file room, desk or office. Unattended means that information is not being observed by an employee authorized to access the information. DHCS PHI or PI in paper form shall not be left unattended at any time in vehicles or planes and shall not be checked in baggage on commercial airplanes.
- B. *Escorting Visitors.*** Visitors to areas where DHCS PHI or PI is contained shall be escorted and DHCS PHI or PI shall be kept out of sight while visitors are in the area.
- C. *Confidential Destruction.*** DHCS PHI or PI must be disposed of through

Exhibit G, Attachment A
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

confidential means, such as cross cut shredding and pulverizing.

- D. *Removal of Data.*** DHCS PHI or PI must not be removed from the premises of the Contractor except with express written permission of DHCS.
- E. *Faxing.*** Faxes containing DHCS PHI or PI shall not be left unattended and fax machines shall be in secure areas. Faxes shall contain a confidentiality statement notifying persons receiving faxes in error to destroy them. Fax numbers shall be verified with the intended recipient before sending the fax.
- F. *Mailing.*** Mailings of DHCS PHI or PI shall be sealed and secured from damage or inappropriate viewing of PHI or PI to the extent possible. Mailings which include 500 or more individually identifiable records of DHCS PHI or PI in a single package shall be sent using a tracked mailing method which includes verification of delivery and receipt, unless the prior written permission of DHCS to use another method is obtained.