

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

Attachment I: Dental MC Boilerplate Contract

The Dental MC boilerplate contract is included for reference in the following attachment.

**EXHIBIT A, ATTACHMENT 1
IMPLEMENTATION PLAN**

This Implementation Plan Deliverables Attachment describe DHCS requirements for specific deliverables, activities, and timeframes that the Contractor must complete during the Implementation Period before beginning Operations, unless otherwise specified herein. Contractor is expected to update throughout the duration of this contract.

All of the items required by this Attachment must be submitted for approval to DHCS thirty (30) days after contract effective date. Unless specified otherwise herein, Contractor shall have a continuing obligation to update the deliverables required by this attachment whenever the information in the deliverables changes in any material respect, or upon revision requested by DHCS. This obligation extends for the duration of this contract; updates should be submitted to DHCS, for review and approval, no later than thirty (30) calendar days of any material change. The approval process for updates shall be in accordance with Exhibit E, Attachment 2, Duties of the State, Provision E, Approval Process for Submitted Materials during Operations. Unless expressly requested by DHCS, Contractor is not required to submit any of the items in this attachment if the item contains current information and is currently on file with DHCS. All submitted financial information must adhere to Generally Accepted Accounting Principles (GAAP), unless otherwise noted.

Contractor shall submit:

A. Organization and Administration of Plan

Submit the following consistent with the requirements of Exhibit A, Attachment 2.

1. Submit documentation of employees (current and former State employees) who may present a conflict of interest.
2. Submit a complete organizational chart.
3. Submit the following Knox-Keene license exhibits and forms found in 28 CCR 1300.51 et seq reflecting current operation status:
 - a. Type of Organization: Submit the following applicable exhibits and forms as appropriate for its type of organization and administration of the dental plan.
 - 1) Corporation: Exhibits F-1-a-i through F-1-a-iii and Corporation Information Form, Form HP 1300.51-A.
 - 2) Partnership: Exhibits F-1-b-i and F-1-b-ii and Partnership Information Form, Form HP 1300.51-B.
 - 3) Sole Proprietorship: Exhibit F-1-c and Sole Proprietorship Information Form, Form HP 1300.51-C.

4) Other Organization: Exhibits F-1-d and F-1-d-ii, and Information Form for other than Corporations, Partnerships, and Sole Proprietorships, Form HP 1300.51-D.

5) Public Agency: Exhibits F-1-e-I through F-1-e-iii.

28 CR 1300.51(d)F1a – e

b. Exhibit F-1-f: Individual Information Sheet (Form HP 1300.51.1) for each person named in response to item 1) above.

28 CR 1300.51(d)F1f

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

28 CR 1300.51(d)F2

d. Exhibit F-3 Other Controlling Persons.

28 CR 1300.51(d)F

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

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

28 CCR 1300.51(d)N1&2

B. Financial Information

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

1. Submit most recent audited annual financial reports, prepared by a certified public accountant.
2. Submit quarterly financial statements with the most recent quarter prior to execution of the contract.
3. Submit the following Knox-Keene license exhibits reflecting projected financial viability:
 - a. Exhibit HH-1
 - b. Exhibit HH-2(28 CCR 1300.76)

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

28 CCR 1300.51(d)(HH)
5. Describe any risk sharing or incentive arrangements. Explain any intent to enter into a stop loss option with DHCS. Also describe any reinsurance and risk-sharing arrangements with any subcontractors shown in this proposal. Submit copies of all policies and agreements. For regulations related to Assumption of Financial Risk and Reinsurance, see 22 CCR 53863 and 53868.
6. Fiscal Arrangements: Submit the following Knox-Keene license exhibits reflecting current operation status:
 - a. Exhibit II-1
 - b. Exhibit II-2
 - c. Exhibit II-3

28 CR 1300.51(d)(II)
7. Describe systems for ensuring that subcontractors, who are at risk for providing services to Medi-Cal Members, as well as any obligations or requirements delegated pursuant to a subcontract, have the administrative and financial capacity to meet its contractual obligations. (28 CCR 1300.70(b)(2)(H)1 and 22 CCR 53250.)
8. Submit financial policies that relate to Contractor's systems for budgeting and operations forecasting. The policies should include comparison of actual operations to budgeted operations, timelines used in the budgetary process, number of years prospective forecasting is performed, and variance analysis and follow-up procedures.
9. Submit policies and procedures for a system to evaluate and monitor the financial viability of all subcontracting entities.

C. Management Information System (MIS)

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

1. Submit a completed Managed Care Organization (MCO) Baseline Assessment Form.
2. When procuring a new MIS or modifying a current system, Contractor shall provide a detailed implementation plan that includes:
 - a. Outline of the tasks required;
 - b. The major milestones;
 - c. The responsible party for all related tasks;
 - d. A full description of the acquisition of software and hardware, including the schedule for implementation;
 - e. Full documentation of support for software and hardware by the manufacturer or other contracted party;
 - f. System test flows through a documented process that has specific control points where evaluation data can be utilized to correct any deviations from expected results;
 - g. Documentation of system changes related to the Health Insurance Portability and Accountability Act of 1996 requirements.
3. Submit a detailed description of how Contractor will monitor the flow of encounter data from provider level to the organization.
4. An encounter data test produced from test data processed by the MIS must be submitted. Monthly encounter submissions may not take place until this test has been successfully completed.
5. Submit policies and procedures for the complete, accurate, and timely submission of encounter-level data.
6. Submit a work plan for compliance with the Health Insurance Portability and Accountability Act of 1996.
7. Submit the data security, backup, or other data disaster processes used in the event of a MIS failure.
8. Contractor's MIS will be reviewed against the model MIS guidelines. Submit a detailed description of the proposed and/or existing MIS as it relates to the following subsystems:
 - a. Financial
 - b. Member/Eligibility
 - c. Provider
 - d. Encounter/Claims
 - e. Quality Management/Utilization

9. Submit a sample and description of the following reports generated by the MIS:

- a. Member roster
- b. Provider Listing
- c. Capitation payments
- d. Cost and Utilization
- e. System edits/audits
- f. Claims payment status/processing
- g. Quality Assurance
- h. Utilization
- i. Monitoring of Complaints

D. Quality Improvement System (QIS)

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

1. Submit a written description of the QIS, including:
 - a. A flow chart and/or organization chart identifying all components of the QIS and who is involved and responsible for each activity.
 - b. A description of the responsibility of the governing body in the QIS.
 - c. A description of the QI Committee, including Membership, activities, roles and responsibilities.
 - d. A description of how providers will be kept informed of the written QIS, its activities and outcomes.
2. Submit policies and procedures related to the delegation of the QIS activities.
3. Submit boilerplate subcontract language showing accountability of delegated QIS functions and responsibilities.
4. Policies and procedures to address how the Contractor will meet the requirements of:
 - a. Quality Improvement Projects
 - b. Consumer Satisfaction Survey
 - c. Performance Measures
5. Policies and procedures for performance of Primary Care Dentist and specialist site reviews.
6. A list of sites to be reviewed prior to initiating plan operation, existing or in expanded areas.
7. The aggregate results of pre-operational, existing or in expanded areas, site review to DHCS at least six (6) weeks prior to plan operation. The aggregate results shall include all data elements defined by DHCS.

8. Policies and procedures for provider profiling and audits.
9. Policies and procedures for credentialing and revalidation, including licensure and certification of providers and facilities.
10. Policies and procedures for disciplinary actions including, reducing, suspending, or terminating a provider's privileges.

E. Utilization Management (UM)

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

1. Submit written description of UM program that describes appropriate processes to be used to review and approve the provision of dental services. Include:
 - a. Procedures for pre-authorization.
 - b. A list of services requiring prior authorization and the utilization review criteria.
 - c. Procedures for the utilization review appeals process for providers and Members.
 - d. Procedures that specify timeframes for dental authorization.
 - e. Procedures to detect both under- and over-utilization of dental care services.
2. Submit policies and procedures showing how delegated activities will be regularly evaluated for compliance with contract requirements and, that any issues identified through the UM program are appropriately resolved, and that UM activities are properly documented and reported.

F. Provider Network

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

1. Submit a complete provider network that is adequate to provide required covered services for Members in the service area.
2. Submit policies and procedures describing how Contractor will monitor provider to patient ratios to ensure they are within specified standards.
3. Submit policies and procedures regarding dentist supervision of non-dentist practitioners.
4. Submit policies and procedures for providing emergency services.
5. Submit a **complete list** of specialists by type within the Contractor's network.
6. Submit policies and procedures for how Contractor will meet federal requirements for access and reimbursement for in- network and/or out-of- network **Indian Health Care Providers (IHCP) and** Federally Qualified Health Centers (FQHC) services

consistent with Exhibit A, Attachment 8, Provider Network, Provision L, Subcontracts with FQHCs, Rural Health Clinics (RHC) and ~~Indian Health Service Facilities~~ **IHCPs**.

7. Submit a GeoAccess report (or similar) showing that the proposed provider network meets the appropriate time and distance standards set forth in Exhibit A, Attachment 8, Provider Network, Provision E, Time and Distance Standard of the Contract.
8. Submit a report containing the names of all subcontracting provider groups (see Exhibit A, Attachment 8, Provider Network, Provision H, Plan Provider Network).
9. Submit an analysis demonstrating the ability of the Contractor's provider network to meet the ethnic, cultural, and linguistic needs of the Contractor's Members.
10. Submit all boilerplate subcontracts, signature page of all subcontracts, and reimbursement rates. DHCS will maintain the confidentiality of the rates to the extent provided by State law.

G. Provider Relations

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

1. Submit policies and procedures for provider grievances.
2. Submit protocols for payment and communication with non-contracting providers.
3. Submit copy of Provider Manual.

H. Provider Compensation Arrangements

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

1. Submit policies and procedures for processing and payment of claims.
2. Submit excerpt from the Provider Manual that describes the prohibition of a claim or demand for services provided under the Medi-Cal Dental Managed Care contract, to any Member.
3. Submit Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), and ~~Indian Health Service Facilities~~ **Care Providers (IHCP)** Subcontracts.
4. Submit schedule of capitation rates and/or fee-for-service rates for each of the following provider types:
 - a. Primary Care Dentists
 - b. Specialists
 - c. FQHC

- d. RHC
- e. IHCP Indian Health Service Facility

I. Access and Availability

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

1. Submit policies and procedures that include standards for:
 - a. Appointment scheduling
 - b. Routine specialty referral
 - c. Waiting times
 - d. After-hours calls
 - e. Specialty services
2. Submit policies and procedures for the timely referral and coordination of covered services to which the Contractor or subcontractor has objections to perform or otherwise support, consistent with Exhibit A, Attachment 11, Access and Availability, Provision C, Access to Services Which Contractor or Subcontractor has a Moral Objection.
3. Submit policies and procedures for standing referrals.
4. Submit policies and procedures regarding 24-hours-a-day access without prior authorization for emergency dental care services.
5. Submit policies and procedures regarding access for disabled Members pursuant to the Americans with Disabilities Act of 1990.
6. Submit policies and procedures regarding Contractor and subcontractor compliance with the Civil Rights Act of 1964.
7. Submit policies and procedures for the provision of 24-hour-a-day interpreter services at all provider network sites.
8. Submit policies and procedures for disaster recovery.

J. Scope of Services

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

1. Submit policies and procedures, including standards, for the provision of the following services for Members under 21 years of age:
 - a. EPSDT supplemental services

2. Provide a detailed description of the dental health education system including policies and procedures which address:
 - a. Oversight of the Dental Health Education Program;
 - b. Delivery of Dental Health Education Programs, Services and Resources;
 - c. Evaluation and Monitoring of the Dental Health Education System;
 - d. Content of the Dental Health Education Program.

K. Case Management and Coordination of Care

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

1. Submit procedures for monitoring the coordination of care provided to Members.

For the remaining items, if these items are included in the Provider Manual, submitted under item G.3, provide a table/list of where the items can be found in the Provider Manual. Otherwise, submit each item as listed below and include a description of how they are communicated to network providers.

2. Submit policies and procedures for coordinating care of Members who are receiving services from a Primary Care Dentist.
3. Submit policies and procedures for the referral of Members under the age of 21 years that require case management services.
4. Submit a detailed description of Contractor's program for Children with Special Health Care Needs (CSHCN).
5. Submit policies and procedures for identifying and referring children with California Children Services (CCS)-eligible conditions to the local CCS program.
6. Submit policies and procedures for the provision of covered dental services.

L. Member Services

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

1. Submit policies and procedures that address Member's rights and responsibilities. Include method for communicating them to both Members and providers.
2. Submit policies and procedures for the training of Member Services staff.
3. Submit policies and procedures regarding the development content and distribution of information to Members. Address appropriate reading level and translation of materials and include evidence that the materials are at that level.

4. Submit final draft of Member Identification Card and Member Services Guide (Evidence of Coverage and Disclosure Form).
5. Submit policies and procedures for Member selection of a Primary Care Dentist.
6. Submit policies and procedures for Member assignment to a Primary Care Dentist.
7. Submit policies and procedures for notifying Primary Care Dentist that a member has selected or been assigned to the provider within ten (10) calendar days.
8. Submit policies and procedures for notifying Members for denial, deferral, or modification of requests for prior authorization.

M. Member Grievance and Appeal System

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

1. Submit policies and procedures relating to Contractor's Member grievance and appeal system.
2. Submit policies and procedures for Contractor's oversight of the Member grievance and appeal system for the receipts, processing and distribution including the expedited review of grievances. Please include a flow chart to demonstrate the process.

N. Enrollments and Disenrollments

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

1. Submit policies and procedures for how Contractor will update and maintain accurate information on its contracting Providers.
2. Submit policies and procedures for how Contractor will access and utilize enrollment data from DHCS.
3. Submit policies and procedures relating to Members disenrollment, including Contractor initiated disenrollment.

O. Marketing

Submit the following consistent with the requirements of Exhibit A, Attachment 17.

1. Submit Contractor's marketing plan, including training program and certification of marketing representatives.

2. Submit a copy of boilerplate request form used to obtain DHCS approval of participation in a marketing event.

P. Confidentiality of Medical Information

Submit the following consistent with the requirements of Exhibit E, Additional Provisions, Provision 22, Confidentiality of Medical Information.

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

**ATTACHMENT 1-A
IMPLEMENTATION PLAN DELIVERABLE**

Plan Name _____

All implementation deliverables are due 30 days after contract effective date and prior to contract operations. See Exhibit A, Attachment 1, Provision A thru P, for list and details of individual deliverables.

Deliverable	Provision	Date Submitted	Completed
Conflict of Interest documentation for employees	Exhibit A, Attachment 2, Provision C		
Organization chart	Exhibit A, Attachment 2, Provision D		
Knox Keene License exhibits and forms	Exhibit A, Attachment 2, Provision A		
Audited annual financial reports	Exhibit A, Attachment 3, Provision B		
Quarterly financial statement issued prior to contract	Exhibit A, Attachment 3, Provision B		
Knox Keene financial exhibits HH-1, HH-2, projected Medi-Cal enrollment/month	Exhibit A, Attachment 3		
Knox Keene financial exhibits HH-6	Exhibit A, Attachment 3		
Risk sharing/incentive arrangements	Exhibit A, Attachment 3		
Knox Keene exhibits II-1, II-2 and II-3	Exhibit A, Attachment 3		
Subcontractors admin and financial capacity to provide at risk services	Exhibit A, Attachment 3		
Financial Policy for budgeting and operations forecasting.	Exhibit A, Attachment 3		
Policy to monitor financial viability for subcontractors	Exhibit A, Attachment 3		
Managed Care Organization Baseline Assessment form	RFP Main, Attachment 13		

Plan for procuring new or modifying MIS system	Exhibit A, Attachment 4		
Process for encounter data flow	Exhibit A, Attachment 4, Provision B		
Encounter data test	Exhibit A, Attachment 4, Provision A		
Policy for encounter data submission	Exhibit A, Attachment 4, Provision B		
Work plan for HIPAA compliance	Exhibit A, Attachment 4, Provision D		
Process for data security, backup, disaster	Exhibit A, Attachment 4, Provision E		
Process for MIS subsystems	Exhibit A, Attachment 4, Provision A		
Sample and description of MIS reports	Exhibit A, Attachment 4, Provision A		
Description of QIS	Exhibit A, Attachment 5		
Policy related to delegation of QIS activities	Exhibit A, Attachment 5, Provision F		
Boilerplate subcontract language of QIS functions and responsibilities.	Exhibit A, Attachment 5, Provision F		
Policy to address Contractor requirements	Exhibit A, Attachment 5, Provision G		
Policy for Primary Care Dentist (PCD) site reviews	Exhibit A, Attachment 5, Provision K		
List of site reviews prior to operation	Exhibit A, Attachment 5, Provision K		
Aggregate results of site review	Exhibit A, Attachment 5, Provision K		
Policy for provider profiling and audits	Exhibit A, Attachment 5, Provision K		
Policy for provider credentialing and revalidation	Exhibit A, Attachment 5, Provision L		
Policy for disciplinary actions	Exhibit A, Attachment 5, Provision K		
Processes of Utilization Management program	Exhibit A, Attachment 7, Provision A		

Policy for evaluating UM activities for compliance	Exhibit A, Attachment 7, Provision A		
Complete provider network	Exhibit A, Attachment 8, Provision A		
Policy for monitoring provider to patient ratios	Exhibit A, Attachment 8, Provision B		
Policy regarding dentist supervision of non-dentist practitioners	Exhibit A, Attachment 8		
Policy for providing emergency services	Exhibit A, Attachment 8, Provision C		
Complete list of specialists	Exhibit A, Attachment 8, Provision D		
Policy for reimbursement of FQHC, RHC and Indian Health Service Facility IHCP	Exhibit A, Attachment 8, Provision L		
GeoAccess report of provider networks	Exhibit A, Attachment 8, Provision G		
Report of all subcontracting provider groups	Exhibit A, Attachment 8, Provision H		
Analysis of provider network meeting ethnic, cultural and linguistic needs of Members	Exhibit A, Attachment 8, Provision I		
All boilerplate subcontracts	Exhibit A, Attachment 8, Provision J		
Policy for provider grievance <u>appeals</u>	Exhibit A, Attachment 9, Provision B		
Policy for payment of non-contracting providers	Exhibit A, Attachment 9, Provision C		
Provider Manual	Exhibit A, Attachment 9, Provision D		
Policy for payment of claims	Exhibit A, Attachment 10, Provision D		
Excerpt from Provider Manual describing prohibition of claim or	Exhibit A, Attachment 10, Provision E		

demand for services			
FQHC, RHC and Indian Health Service subcontracts	Exhibit A, Attachment 10, Provision F		
Schedule of per diem rate and/or FFS rate for each provider type	Exhibit A, Attachment 10, Provision A		
Policy for access and availability standards	Exhibit A, Attachment 11, Provision B		
Policy for referrals	Exhibit A, Attachment 11, Provision B		
Policy for emergency access to services	Exhibit A, Attachment 11, Provision D		
Policy for disabled Members	Exhibit A, Attachment 11, Provision F		
Policy for compliance with Civil Rights Act of 1964	Exhibit A, Attachment 11, Provision G		
Policy for 24 hour interpreter services	Exhibit A, Attachment 11, Provision H		
Policy for disaster recovery	Exhibit A, Attachment 11, Provision I		
Policy for EPSDT services	Exhibit A, Attachment 12, Provision C		
Policy for health education system	Exhibit A, Attachment 12, Provision D		
Policy for coordination of care	Exhibit A, Attachment 13		
Policy that address Members' rights and responsibilities	Exhibit A, Attachment 14, Provision A		
Policy for training of Members Services Staff	Exhibit A, Attachment 14, Provision B		
Policy to provide information to Members	Exhibit A, Attachment 14, Provision D		
Member Identification Card and Member Services Guide	Exhibit A, Attachment 14, Provision D		

Policy regarding Member selection of PCD	Exhibit A, Attachment 14, Provision F		
Policy regarding Member assignment to PCD	Exhibit A, Attachment 14, Provision G		
Policy notifying PCD of Member assignment or selection	Exhibit A, Attachment 14, Provision G		
Policy notifying Members of action on prior authorization	Exhibit A, Attachment 14, Provision H		
Policy for Member grievance <u>and appeal</u> system	Exhibit A, Attachment 15, Provision A & B		
Policy for oversight of Member grievance <u>and appeal</u> system	Exhibit A, Attachment 15, Provision B		
Policy regarding accurate information on providers	Exhibit A, Attachment 16, Provision A		
Policy for utilization of enrollment data from DHCS	Exhibit A, Attachment 16, Provision B		
Policy for Member disenrollment	Exhibit A, Attachment 16, Provision D		
Marketing plan	Exhibit A, Attachment 17, Provision C		
Boilerplate request form to obtain DHCS marketing approval	Exhibit A, Attachment 17, Provision B		
Policy addressing Members right to confidentiality of medical/dental information	Exhibit E, Additional Provisions, Provision 22		

**EXHIBIT A, ATTACHMENT 2
ORGANIZATION AND ADMINISTRATION OF THE PLAN**

A. Legal Capacity

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

B. Key Personnel (Disclosure Form)

1. Contractor shall file an annual statement with DHCS, no later than thirty (30) calendar days after the beginning of the calendar year, disclosing any purchases or leases of services, equipment, supplies, or real property from an entity in which any of the following persons have a substantial financial interest:
 - a. Any person or corporation also having 5% or more ownership or controlling interest in the Contractor.
 - b. Any director, officer, partner, trustee, or employee of the Contractor.
 - c. Any member of the immediate family of any person designated in a. or b. above.

2. Contractor must submit to DHCS the following disclosures noted below:

- a. **For any person (individual corporation) with an ownership or control interest in the Contractor or its subcontractors:**
 - i. **The name and address. The address for corporate entities must include the primary business address, every business location, and P.O. Box address, as applicable.**
 - ii. **The date of birth and Social Security Number (in the case of an individual).**
- b. **Other tax identification number of any corporation with:**
 - i. **An ownership or control interest in the Contractor.**
 - ii. **Any subcontractor in which the Contractor has 5 percent or more interest.**
- c. **The name of any other disclosing entity in which an owner of the Contractor has an ownership or control interest.**
- d. **The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity.**

- e. Disclosures pursuant to 42 CFR § 455.104(b) at the following times:
 - i. When the Contractor submits a proposal in accordance with DHCS' procurement process.
 - ii. When the Contractor executes a contract with DHCS.
 - iii. When DHCS renews or extends its contract with the Contractor.
 - iv. Within 35 days of any change in ownership of the Contractor.
 - f. Any other data, documentation, or information relating to the performance of the entity's obligations pursuant to 42 CFR § 438.604 required by DHCS.
- 3.** Contractor shall comply with federal regulations 42 CFR 455.104 (Disclosure by providers and fiscal agents: Information on ownership and control), 42 CFR 455.105 (Disclosure by providers: Information related to business transactions), 42 CFR 455.106 and 42 CFR 438.610 (Prohibited Affiliations with Individuals Debarred by Federal Agencies).
- a. Contractor may not knowingly have a relationship of the type described in paragraph c. of this section with the following:
 - 1) An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under federal Executive Order No. 12549 of February 18, 1986 or under guidelines implementing Executive Order No. 12549.
 - 2) An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation at 48 CFR 2.101, of a person described in paragraph a.1) of this section.
 - b. Contractor may not have a relationship with an individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Social Security Act.
 - c. The relationships described in paragraph a. of this section, are as follows:
 - 1) A director, officer, or partner of the Contractor.
 - 2) A subcontractor of the Contractor, as governed by 42 CFR 438.230.
 - 3) A person with beneficial ownership of 5 percent or more of the Contractor's equity.

- 4) A network provider or person with an employment, consulting or other arrangement with the Contractor for the provision of items and services.

d. If DHCS finds that Contractor is not in compliance with paragraphs (a) or (b) of this section, DHCS:

- 1) May continue an existing agreement with Contractor unless the Secretary of Health and Human Services directs otherwise.
- 2) DHCS may not renew or extend the existing agreement with the Contractor unless the Secretary of Health and Human Services provides to DHCS and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliations.

C. Conflict Of Interest – Current and Former State Employees

1. This Contract shall be governed by the Conflict of Interest provisions of title 22 CCR § 53600.
4. 2. Contractor shall not utilize, in the performance of this Contract, any State officer or employee in the State civil service or other appointed State official unless the employment, activity, or enterprise is required as a condition of the officer's or employee's regular State employment. Contractor shall not utilize, in the performance of this Contract, any former State officer or employee or other appointed official in violation of the provisions of Government Code Section 87406. For purposes of this Sub-provision 2 only, employee in the State civil service is defined to be any person legally holding a permanent or intermittent position in the State civil service.

D. Contract Performance

Contractor shall maintain the organization and staffing for implementing and operating the Contract in accordance with 28 CCR 1300.67.3 and 22 CCR 53900 et seq. Contractor shall ensure:

1. The organization has an accountable governing body.
2. That the Contractor is committed to making this Contract a high priority and supplying any necessary resources to assure full performance of the Contract.
3. The parent organization, if Contractor is a subsidiary, shall attest to the compliance and successful fulfillment of the terms, conditions, provisions and responsibilities set forth in this Contract. The parent organization shall also attest to providing any and all necessary resources to assure full performance of the Contract.

4. Staffing in fiscal, administrative, dental and other dental health services are sufficient to result in the effective conduct of the Contractor's business.
5. There are written procedures for the conduct of the business of the Contractor, including the provision of dental services, so as to provide effective controls.

E. Dental Clinical Decisions

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

F. Dental Director

Contractor shall maintain a full time Dentist as Dental Director pursuant to 22 CCR 53913.5. The Dental Director must maintain a current dental license with the State of California at all times. The license must be in good standing at the time of hire and throughout their employment. The Dental Director shall not be under any sanction or adverse action by Medicaid, or under investigation by the Audits & Investigations Division of DHCS, Department of Justice or any other law enforcement agency. The Dental Director's responsibilities shall include, but not be limited to, the following:

1. Ensuring that dental decisions are:
 - a. Rendered by qualified dental personnel.
 - b. Are not unduly influenced by fiscal or administrative management considerations.
2. Ensuring that the dental care provided meets the standards for acceptable dental care.
3. Ensuring that dental protocols and rules of conduct for plan dental personnel are followed.
4. Developing and implementing dental policy.
5. Resolving grievances related to dental quality of care.
6. Direct involvement in the implementation of Quality Improvement activities.
7. Actively participate in the functioning of the Contractor's grievance procedures as specified in Exhibit A, Attachment 15, Member Grievance **and Appeal** System.

G. Dental Director Changes

Contractor shall report in writing to DHCS any changes in the status of the Dental Director within ten (10) calendar days.

H. Administrative Duties/Responsibilities

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

1. Member and Enrollment reporting systems as specified in Exhibit A, Attachment 4, Management Information System, and, Exhibit A, Attachment 14, Member Services, and Exhibit A, Attachment 15, Member Grievance **and Appeal** System.
2. A Member grievance **and appeal** procedure, as specified in Exhibit A, Attachment 15, Member Grievance **and Appeal** System.
3. Data reporting capabilities sufficient to provide necessary and timely reports to DHCS, as required by Exhibit A, Attachment 4, Management Information System.
4. A full time financial officer to maintain financial records and books of account maintained on the accrual basis, in accordance with Generally Accepted Accounting Principles, which fully disclose the disposition of all Medi-Cal program funds received, as specified in Exhibit A, Attachment 3, Financial Information.
5. Claims processing capabilities as described in Exhibit A, Attachment 10, Provider Compensation Arrangements, Provision E, Claims Processing.
6. A system for providing Members dental health education services and clinical Preventive Services consistent with Exhibit A, Attachment 12, Scope of Services, Provision D, Services for All Members.
7. A provider Grievance **Appeal** procedure.
8. A Quality Improvement System consistent with Exhibit A, Attachment 5.
9. Participate in all meetings with the DHCS.
10. Acknowledge or respond to all correspondence from DHCS in writing.

**EXHIBIT A, ATTACHMENT 3
FINANCIAL INFORMATION****A. Financial Viability/Standards Compliance**

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

1. Tangible Net Equity (TNE).

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

2. Minimum Loss Ratio (MLR)

- a. The Contractor agrees that once the Contractor's plan has a minimum of 1,000 enrolled Members per month for six or more months of a benefit year, the minimum loss ratio for services provided to all Members pursuant to this Contract shall be ~~seventy (70)~~ eighty-five (85) percent. For reporting purposes, the Contractor's loss ratio shall be calculated in aggregate for all Members, using the following formula:

a/b

Where "a" is: Total covered benefit and service costs of Contractor, including occurred but not reported claim completion in accordance to 42 CFR 438.8(e)

Where "b" is: Total capitation payments received by Contractor, including any withhold payments, minus taxes, licensing and regulatory fees, in accordance to 42 CFR 438.8(f).

- b. The Contractor shall report the previous benefit year's loss ratio annually ~~thirty (30) days after the Contractor receives any withhold payments,~~ and within 12 months of the end ninety (90) days of the end of the reporting year. The annual report must include, at minimum, the following information:

- 1) Total incurred claims;
- 2) Expenditures on quality improving activities;
- 3) Expenditures related to activities compliant with program integrity requirements under 42 CFR 438.608(a)(1) through (5), (7), (8) and (b);
- 4) Non-claims costs;
- 5) Premium revenue;
- 6) Taxes, licensing and regulatory fees;
- 7) Methodology for allocation of expenditures;
- 8) Any credibility adjustment applied;
- 9) The calculated MLR;
- 10) Any remittance owed to DHCS, if applicable;
- 11) A comparison of the information reported with the audited financial report;

12) A description of the aggregation method used to calculate total incurred claims; and

13) The number of member months.

- c. The Contractor understands that DHCS may make the results of the loss ratio report listed in Item 2 above available to the public.
- d. The Contractor agrees that if the administrative costs exceed ~~fifteen (15)~~ MLR does not meet the minimum MLR standard of eighty-five (85) percent, DHCS shall have the right to recover from Contractor the amount that is in excess.
- e. The Contractor agrees that in the event of a retroactive change to the capitation payments for a MLR reporting year where the MLR report has already been submitted to the state, the Contractor must recalculate and submit a new MLR report meeting the applicable requirements.
- f. The Contractor will aggregate data for all Member groups covered under the contract with the state unless the state requires separate reporting and a separate MLR calculation for specific members.
- g. The Contractor must attest to the accuracy of the calculation of the MLR in accordance with 42 CFR 438.8.
- h. Contractor agrees that each expense must be included under only one type of expense, unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense must be pro-rated between types of expenses. Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be reported on a pro rata basis. Allocation to each category must be based on a generally accepted accounting method that is expected to yield the most accurate results. Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the contract incurring the expense. Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to the other entities.
- i. The Contractor may add a credibility adjustment to a calculated MLR if the MLR reporting year experience is partially credible prior to the State recovering excess administrative costs in accordance with 42 CFR 438.8. The credibility adjustment is added before calculating any remittances. If the MLR year is fully credible, then no adjustment is allowed.
- j. If the Contractor's MLR experience is non-credible, it is presumed to meet or exceed the MLR calculation standards.
- k. The Contractor must submit a comparison of the information reported with the audited financial report along with MLR report.

- I. If the Contractor uses any third party vendor to provide claims adjudication, they must require the vendor, for adjudication activities, to provide all underlying data associated with MLR reporting to the Contractor within 180 days of the end of the MLR reporting year or within 30 days of being requested by the Contractor, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting.
3. Standards of Organization and Financial Soundness.

Contractor shall maintain an organizational structure sufficient to conduct the proposed operations and ensure that its financial resources are sufficient for sound business operations in accordance with 28 CCR 1300.67.3, 1300.75.1, 1300.76.3, 1300.77.1, 1300.77.2, 1300.77.3, 1300.77.4, and Health and Safety Code Section 1375.1.
4. Working capital and current ratio of one of the following:
 - a. Contractor shall maintain a working capital ratio of at least 1:1; or
 - b. Contractor shall demonstrate to DHCS that Contractor is meeting financial obligations on a timely basis and has been doing so for at least the preceding 24 months; or
 - c. Contractor shall provide evidence that sufficient noncurrent assets, which are readily convertible to cash, are available to achieve an equivalent working capital ratio of 1:1, if the noncurrent assets are considered current.

B. Financial Audit Reports

Contractor shall ensure that an annual audit is performed according to Welfare and Institutions Code ~~§Section~~ 14459. Financial statements audited by a Certified Public Accountant shall be submitted to DHCS no later than one-hundred and twenty (120) calendar days after the close of Contractor's fiscal year. Combined financial statements shall be prepared to show the financial position of the overall related health care delivery system when delivery of care or other services is dependent upon Affiliates. Financial statements shall be presented in a form that clearly shows the financial position of Contractor separately from the combined totals. Inter-entity transactions and profits shall be eliminated if combined statements are prepared. If an independent accountant decides that preparation of combined statements is inappropriate, Contractor shall have separate certified financial statements prepared for each entity.

1. The independent accountant shall state in writing reasons for not preparing combined financial statements.
2. Contractor shall provide supplemental schedules that clearly reflect all inter-entity transactions and eliminations necessary to enable DHCS to analyze the overall financial status of the entire health care delivery system.

3. In addition to annual certified financial statements, Contractor shall complete the State Department of Managed Health Care (DMHC) required financial reporting forms. The DMHC required financial reporting forms shall be submitted to DHCS no later than one hundred-twenty (120) calendar days after the close of Contractor's Fiscal Year.
4. Contractor shall submit to DHCS, no later than ninety (90) calendar days after the close of the State's fiscal year, a Statement of Revenues and Expenses for Medi-Cal Dental only using the reporting forms in Exhibit A, Attachment 20, Deliverable Templates.
5. Contractor shall submit to DHCS within thirty (30) calendar days after the close of Contractor's fiscal quarter, quarterly financial reports. The required quarterly financial reports shall be prepared on the DMHC required financial reporting forms and shall include, at a minimum, the following reports/schedules:
 - a. Jurat
 - b. Report 1A and 1B: Balance Sheet
 - c. Report 2: Statement of Revenue, Expenses, and Net Worth
 - d. Statement of Cash Flow, prepared in accordance with Financial Accounting Standards Board Statement Number 95. (This statement is prepared in lieu of Report #3: Statement of Changes in Financial Position for Generally Accepted Accounting Principles (GAAP) compliance.)
 - e. Report 4: Enrollment and Utilization Table
 - f. Schedule F: Unpaid Claims Analysis
 - g. Appropriate footnote disclosures in accordance with GAAP
 - h. Schedule H: Aging Of All Claims
6. Contractor shall authorize its independent accountant to allow DHCS designated representatives or agents, upon written request, to inspect any and all working papers related to the preparation of the audit report.
7. Contractor shall submit to DHCS all financial reports relevant to Affiliates.
8. Contractor shall submit to DHCS copies of any financial reports submitted to other public or private organizations if such reports differ in content from any financial report already submitted to DHCS.

-
9. Contractor shall submit to DHCS, within forty-five (45) calendar days after the close of State's fiscal quarter, a Statement of Revenues and Expenses for Medi-Cal Dental only using the reporting form in Exhibit A, Attachment 20, Deliverable Templates.

C. Monthly Financial Statements

If Contractor and/or subcontractor is required to file monthly Financial Statements with the DMHC, Contractor and/or subcontractor shall simultaneously file an exact copy of the monthly Financial Statements with DHCS.

D. Compliance with Audit Requirements

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

E. Submittal of Financial Information

Contractor shall prepare financial information requested in accordance with GAAP. Where Financial Statements and projections are requested, these statements and projections should be prepared in accordance with the 1989 HMO Financial Report of Affairs and Conditions Format. Where appropriate, reference has been made to the Knox-Keene Health Care Service Plan Act of 1975 rules found in 28 CCR 1300.51 et. seq. Information submitted shall be based on current operations. Contractor and/or subcontractors shall submit financial information consistent with filing requirements of the DMHC unless otherwise specified by DHCS.

F. Solvency Standards

- 1. Contractor shall comply with the requirements set forth under 42 CFR § 438.116, which includes, but is not limited to, that the Contractor provide assurances satisfactory to the State showing that its provision against the risk of insolvency is adequate such that it ensures that its Medicaid enrollees shall not be held liable for Contractor's debts if the entity becomes insolvent. Federally qualified Health Maintenance Organization (HMO), as defined in Public Health Safety Act Section §1310, are exempt from this requirement.**
- 2. Contractor shall meet solvency standards established by the State for private health maintenance organizations, or be licensed or certified by the State as a risk-bearing entity. Contractor shall provide the State with a copy of compliance or exception by January 31st of each calendar year. The above requirement does not apply to a Managed Care Organization (MCO), or Prepaid Inpatient Health Plan (PIHP) that meet any of the following conditions:**
 - a. Does not provide both inpatient hospital services and physician services.**
 - b. Is a public entity.**

- c. Is (or is controlled by) one or more Federally Qualified Health Centers and meets the solvency standards established by the State for those centers.
- d. Has its solvency guaranteed by the State.

**EXHIBIT A, ATTACHMENT 4
MANAGEMENT INFORMATION SYSTEM (MIS)****A. Capability**

1. Contractor's MIS shall have the capability to capture, edit, and utilize various data elements for both internal management uses as well as to meet the data quality and timeliness requirements of DHCS' encounter data submission. All data related to this contract shall be available to DHCS and to the Centers for Medicare and Medicaid Services upon request. In addition to the requirements specified in 42 CFR 438.242 (b), Contractor shall have and maintain a MIS that provides, at a minimum:
 - a. All Medi-Cal eligibility data.
 - b. Information of Members enrolled in Contractor's plan.
 - c. Provider claims status and payment data.
 - d. Dental services delivery encounter data to include but not be limited to:
 - 1) Monthly new users;
 - 2) 2) Monthly all users;
 - 3) 3) Monthly eligible;
 - 4) 4) Monthly disenrollment for reasons other than loss of eligibility;
 - 5) 5) Monthly eligible less new users seen in prior months in same calendar year;
 - 6) 6) Total paid to each Dentist, including capitation payment, FFS payment, incentive payment and any other payment;
 - 7) 7) Calculation of required performance measures.
 - 8) 8) The provider who delivers services.
 - e. Grievance and appeals information.
 - e.f. Provider network information including but not limited to:
 - 1) 1) Provider office location;
 - 2) 2) Provider specialties;
 - 3) 3) Service languages.
 - 4) 4) All additional provider directory elements specified in Exhibit A, Attachment 14 Member Services and Beneficiary Support, Provision D, Written Member Information.
 - f.g. Financial information as specified in Exhibit A, Attachment 3, regarding Administrative Duties/Responsibilities.
2. Contractor's MIS shall have processes that support the interactions between Financial, Member/Eligibility; Provider; Encounter Claims; Quality Management/Quality Improvement/Utilization; and Report Generation subsystems. The interactions of the subsystems must be compatible, efficient and successful. Contractor shall be staffed with personnel with expertise and experience necessary to support the MIS system at the commencement of the Operations Period and for the duration of this Contract.

- 4- **3.** Contractor shall comply with all DHCS mandated testing of the MIS to determine Contractor compliance with MIS requirements.

- 4. In accordance with 42 CFR § 433.139(b)-(f), the Contractor shall comply with DHCS's requests to take action to identify, by unique coding, paid claims for Medicaid beneficiaries that contain diagnosis codes that are indicative of trauma, injury, poisoning, and other consequences of external causes, for the**

purpose of determining the legal liability of third parties so that DHCS may process claims under third party liability payment procedures.

B. Encounter Data Submittal

Contractor shall implement policies and procedures for ensuring the complete, accurate, and timely submission of encounter data for all services for which Contractor has incurred any financial liability, whether directly or through subcontracts or other arrangements. Encounter data shall include data elements specified in DHCS' latest version of the Managed Care Plans, Encounter Data Element Dictionary and All Plan Letters (APL) related to encounter data reporting for Medi-Cal Dental Managed Care Plan contractors **in the form and manner prescribed in 42 CFR § 438.818. The contractor shall submit encounter data to the state in standardized Accredited Standards Committee (ASC) X12N 837 and National Council for Prescription Drug Programs (NCPDP) formats, and the ASC X12N 835 format as appropriate.**

Contractor shall require subcontractors and non-contracting Providers to provide encounter data to Contractor, which allows the Contractor to meet its administrative functions and the requirements set forth in this section. Contractor shall have in place mechanisms, including edits and reporting systems sufficient to assure encounter data is complete, and accurate, **and certified by the CEO or CFO** prior to submission to DHCS **according to Exhibit E, Section 12, Data Certifications**. Contractor shall submit encounter data to DHCS on a monthly basis in the form and manner specified in DHCS' most recent Managed Care Plans, Data Element Dictionary.

Upon written notice by DHCS that the encounter data is insufficient or inaccurate, Contractor shall ensure that corrected data is resubmitted within fifteen (15) calendar days of receipt of DHCS' notice. Upon Contractor's written request, DHCS may provide a written extension for submission of corrected encounter data to be captured in the following month's production run.

If encounter data is not submitted within fifteen (15) calendar days of receipt of DHCS' notice and an approved extension was not attained, DHCS will notify the Contractor in writing of their violation of contract terms and reserves the right to suspend all new enrollments.

C. MIS/Data Correspondence

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

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

Contractor shall comply with Exhibit G, Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements and all federal and State regulations promulgated from HIPAA, as they become effective. The Contractor shall also comply with the requirements of the DHCS' Information Security Office Information Technology Project Security Requirements 1 (SR1). (See Data Library for document)

E. Data Security and Backup

Contractor must submit a data security backup plan to include data disaster recovery processes in the event of an MIS failure for DHCS approval. Contractor shall submit any revisions, updates and/or changes in writing to DHCS for approval fifteen (15) calendar days prior to implementing the proposed revision, update and/or change.

**EXHIBIT A, ATTACHMENT 5
QUALITY IMPROVEMENT SYSTEM****A. General Requirement**

- 1.** Contractor shall implement an effective Quality Improvement System (QIS) in accordance with the standards in 28 CCR §1300.70. Contractor shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. Contractor shall be accountable for the quality of all covered services regardless of the number of contracting and subcontracting layers between Contractor and the provider. This provision does not create a cause of action against the Contractor on behalf of a Medi-Cal beneficiary for malpractice committed by a subcontractor.
- 2.** In accordance with 42 CFR § 438.330, the Contractor shall establish and implement an ongoing comprehensive quality assessment and performance improvement program-which must include at least the following elements:
 - a. Quality Improvement Projects in accordance with Provision H of Exhibit A, Attachment 5, including any required by DHCS or CMS that focus on both and non-clinical areas.
 - b. Collection and submission of performance measurement data required by DHCS or CMS in accordance with Exhibit A, Attachment 6, Performance Measures and Benchmarks.
 - c. Mechanisms to detect both underutilization and overutilization of services.
 - d. Mechanisms to assess the quality and appropriateness of care furnished to Members with special health care needs, as defined by the state, and further specified in Exhibit A, Attachment 13.

B. Accountability

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

C. Governing Body

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

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

D. Quality Improvement Committee

Contractor shall implement and maintain a Quality Improvement Committee designated by, and accountable to, the governing body; the committee shall be facilitated by the dental director or a dentist designee. Contractor must ensure that subcontractors, who are representative of the composition of the contracted provider network including but not limited to subcontractors who provide health care services to seniors and persons with disabilities or chronic conditions (such as asthma, diabetes, congestive heart failure), actively participate on the committee.

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

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

E. Provider Participation

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

F. Delegation of Quality Improvement Activities

1. Contractor is accountable for all quality improvement functions and responsibilities (e.g. Utilization Management, Credentialing and Site Review) that are delegated to subcontractors. If Contractor delegates quality improvement functions, Contractor and delegated entity (subcontractor) shall include in their subcontract, at minimum:
 - a. Quality improvement responsibilities, and specific delegated functions and activities of the Contractor and subcontractor.
 - b. Contractor's oversight, monitoring, and evaluation processes and subcontractor's agreement to such processes.
 - c. Contractor's reporting requirements and approval processes. The agreement shall include subcontractor's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly.
 - d. Contractor's actions/remedies if subcontractor's obligations are not met.
2. Contractor shall maintain a system to ensure accountability for delegated quality improvement activities, that at a minimum:
 - a. Evaluates subcontractor's ability to perform the delegated activities including an initial review to assure that the subcontractor has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities.
 - b. Ensures subcontractor meets standards set forth by the Contractor and DHCS.
 - c. Includes the continuous monitoring, evaluation and approval of the delegated functions.

G. Quality Improvement System (QIS) Manual

Contractor shall implement and maintain a QIS manual. The QIS manual shall be due to DHCS for approval prior to commencement of the contract and any revisions, updates and/or changes shall be submitted in writing to DHCS within fifteen (15) calendar days of the change.

The QIS manual shall include the following:

1. Organizational commitment to the delivery of quality dental services as evidenced by goals and objectives which are approved by Contractor's governing body and periodically evaluated and updated.
2. Organizational chart showing the key staff and the committees and bodies responsible for quality improvement activities including reporting relationships of QIS committee(s) and staff within the Contractor's organization.

3. Qualifications of staff responsible for quality improvement studies and activities, including education, experience and training.
4. A description of the system for provider review of QIS findings, which at a minimum, demonstrates provider and other appropriate professional involvement and includes provisions for providing feedback to staff and providers, regarding QIS study outcomes.
5. The role, structure, and function of the quality improvement committee.
6. The processes and procedures designed to ensure that all medically necessary dental covered services are available and accessible to all Members regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability, and that all covered services are provided in a culturally and linguistically appropriate manner.
7. A description of the mechanisms used to continuously review, evaluate, and improve access to and availability of services, **including detection of both underutilization and overutilization**. The description shall include methods to ensure that Members are able to obtain appointments within established standards. (See Exhibit A, Attachment 11, Access and Availability, Provision B, Access Requirements, Subprovision 2.)
8. Description of the quality of dental services provided, including, but not limited to, preventive services for children and adults, specialty services, and emergency services.
9. Description of the activities designed to assure the provision of case management, coordination and continuity of care services.
10. A description of the process used to track dental and medical referrals from initiation of the referral to the completion.

H. Quality Improvement Projects (QIPs)

1. For this Contract, Contractor is required to conduct or participate in two (2) Quality Improvement Projects (QIPs) per year approved by DHCS. **Each QIP must be designed to achieve significant improvement, sustained over time, in health outcomes and Member satisfaction.**
 - a. One (1) QIP must be either an Internal Quality Improvement Project (IQIP) or a Small Group Collaborative (SGC) facilitated by a dental plan or DHCS. The SGC must include a minimum of two (2) DHCS dental plan contractors and must use standardized measures and clinical practice guidelines.

Additionally, all contracting health plans participating in a SGC must agree to the same goal, timelines for development, implementation, and measurement. Contracting health plans participating in a SGC must also agree on the nature of

contracting health plan commitment of staff and other resources to the collaborative project.

- b. One (1) QIP must be a DHCS established and facilitated Statewide Collaborative beginning after start of operations.
- c. If this Contract covers multiple counties, Contractor must include all counties in a QIP unless otherwise approved by DHCS.
- d. Contractor shall comply with the initial All Plan Letter to be distributed thirty (30) days after contract effective date as well as any subsequent updates, and shall use the QIP reporting format designated therein to request approval of proposed QIPs from DHCS and report at least quarterly to DHCS on the status of each QIP. The required documentation for QIP proposals and for QIP status reports shall include but is not limited to:
 - 1) In-depth qualitative and quantitative analysis of barriers and results.
 - 2) Evidence-based interventions and best practices, when available, and system wide intervention, when appropriate.
 - 3) Interventions that address health disparities.
 - 4) Measurement of performance using objective quality indicators.

5) Implementation of interventions to achieve improvement in the access to and quality of care.

6) Evaluation of the effectiveness of the interventions based on the performance measures in Exhibit A, Attachment 6 Performance Measures and Benchmarks.

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

I. Quality Improvement Annual Report

Contractor shall develop an annual quality improvement report for submission to DHCS on an annual basis due no later than thirty (30) calendar days after the beginning of the calendar year.

The annual report shall include:

1. A comprehensive assessment of the quality improvement activities undertaken and an evaluation of areas of success and needed improvements in services rendered within the quality improvement program, including but not limited to, the collection of aggregate data on utilization; the review of quality of services rendered; the results of

the Performance Measures; and, outcomes/findings from Quality Improvement Projects (QIPs), consumer satisfaction surveys and collaborative initiatives.

2. Copies of all final reports of any non-governmental accrediting agencies relevant to the Contractor's Medi-Cal line of business, including accreditation status and any deficiencies noted. Include the corrective action plan developed to address noted deficiencies.
3. An assessment of subcontractor's performance of delegated quality improvement activities.

J. External Quality Review Requirements

At least annually, or as designated by DHCS, the Contractor shall arrange for an external quality of care review of the Contractor by an entity qualified to conduct such reviews. Contractor shall submit the selected External Quality Review Organization (EQRO) thirty (30) days after contract effective date to be approved by DHCS. Contractor shall be responsible for payment of the EQRO.

1. Performance Measure Audit

The performance measures consist of a set of DHCS developed measures for evaluation of dental plan performance.

- a. On an annual basis, Contractor shall submit to an on-site audit to assess the Contractor's information and reporting systems, as well as the Contractor's methodologies for calculating performance measure rates.
- b. Contractor shall calculate and report all performance measures at the county level for audit by the EQRO.
- c. Contractor shall provide DHCS with a copy of the audit report no later than December 15 or such date as established by DHCS.
- d. Contractor shall meet or exceed the DHCS established benchmark for each performance measure.

2. Consumer Satisfaction Survey

At intervals determined by DHCS, the EQRO will conduct one (1) consumer satisfaction survey per year. The survey of Member satisfaction with plan and providers shall be the same dental version of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey as used by the Healthy Families Program. The survey shall include a representative sample of Members enrolled in Contractor's plan in each county, as determined by the technical specifications of the survey instrument chosen by DHCS. If requested, Contractor shall provide appropriate data to the EQRO to facilitate this survey.

3. Network Adequacy Standards

In accordance with 42 CFR § 438.68, on an annual basis, the EQRO shall validate the Contractor's compliance with the provider network adequacy standards as set forth in Exhibit A, Attachment 1, Provider Network, Provision F.

K. Site Review**1. General Requirement**

Contractor shall conduct site reviews on all Primary Care Dentist and specialist service sites.

2. Pre-Operational Site Reviews

The number of site reviews to be completed prior to initiating plan operation in a service area shall be based upon the total number of new primary dental care and specialist sites in the provider network. For more than thirty (30) sites in the provider network, a five (5) percent sample size or a minimum of thirty (30) sites, whichever is greater in number, shall be reviewed six (6) weeks prior to plan operation. Reviews shall be completed on all remaining sites within six (6) months of plan operation. For thirty (30) or fewer sites, reviews shall be completed on all sites six (6) weeks prior to plan operation.

3. Credentialing Site Review

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

4. Provider Monitoring

Contractor shall monitor its Providers using Quality Improvement thresholds established by DHCS. The quality indicators to be monitored are as follows, but not limited to:

- a. Service site audit findings based on Exhibit A, Attachment 11, Access and Availability, Provision B, Access Requirements, Subprovision 2.
- b. Dental Record (chart) audit findings based on Exhibit A, Attachment 5, Quality Improvement System, Provision M, Dental Records, Subprovision 4.
- c. Utilization Review of Encounter Data based on Encounter Data Submittal requirements in Exhibit A, Attachment 4, Management Information System,

Provision B, Encounter Data Submittal and performance measures in Exhibit A, Attachment 6.

DHCS reserves the right to modify or add additional quality indicators through an All Plan Letter.

Contractor shall review, on a quarterly basis, a minimum of five (5) active providers from their network for compliance with the quality indicators. Contractor shall submit a Provider Monitoring Report, in a format specified by DHCS in Exhibit A, Attachment 20, Deliverable Templates for each Provider reviewed for the quality indicators and any others required through an APL. The report shall detail the quality indicators that each Provider did not meet and describe the Contractor's plan to remediate the deficiency. This report shall include a narrative summary of all Quality Improvement System actions relating to Providers and shall be submitted quarterly to DHCS. The report is due to DHCS within thirty (30) calendar days following the quarter.

If DHCS acquires any negative information regarding a provider subcontracted with the Contractor, the Contractor may be required to conduct a review or audit of that provider.

5. Continuing Oversight

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

L. Credentialing and Revalidation

Contractor shall develop, and maintain uniform written policies and procedures that include initial credentialing, revalidation, recertification, and reappointment of dentists including Primary Care Dentists and specialists in accordance with Dental Managed Care All Plan Letter to be executed at contract effective date and 42 CFR 438.214(b). Contractor shall ensure those policies and procedures are reviewed and approved by the governing body, or designee. Contractor shall ensure that the responsibility for recommendations regarding credentialing decisions will rest with a credentialing committee or other peer review body. Contractor shall submit to DHCS the policies and procedures for initial credentialing, revalidation, recertification, and reappointment of dentists including Primary Care Dentists, specialists and non-dentist practitioners thirty (30) days after contract effective date for review and approval. Any revisions, updates and/or changes shall be submitted in writing to DHCS within fifteen (15) calendar days of the change.

1. Standards

All providers of that deliver covered services and have signed contracts or participation agreements with Contractor, must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered. All providers must have good standing in the Medicare and Medicaid/Medi-Cal programs and must have a valid National Provider

Identifier (NPI) number. Providers that have been terminated from either Medicare or Medicaid/Medi-Cal cannot participate in Contractor's provider network.

2. Delegated Credentialing

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

3. Credentialing Provider organization Certification

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

4. Disciplinary Actions

Contractor shall implement and maintain a system for the reporting of serious quality deficiencies that result in suspension or termination of a provider to DHCS and the appropriate authorities. Contractor shall implement and maintain policies and procedures for disciplinary actions including, reducing, suspending, or terminating a provider's privileges. Contractor shall implement and maintain a provider appeal process. All policies and procedures shall be submitted and approved by DHCS thirty (30) days prior to operations.

5. Medi-Cal and Medicare Provider Status

The Contractor will verify that their subcontracted providers have not been terminated as Medi-Cal or Medicare providers or have not been placed on the Suspended and Ineligible Provider list (www.Medi-Cal.ca.gov). Terminated providers in either Medicare or Medi-Cal/Medicaid or on the Suspended and Ineligible Provider list cannot participate in the Contractor's provider network.

6. Health Plan Accreditation

a. The Contractor shall inform the State whether it has been accredited by a private independent accrediting entity.

b. The Contractor must authorize the private independent accrediting entity to provide the State a copy of its most recent accreditation review, including:

- 1) Accreditation status, survey type, and level (as applicable);**
- 2) Accreditation results, including recommended actions or improvements, corrective action plans, and summaries of finding;**
- 3) Expiration date of the accreditation.**

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

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

7. Credentialing of Other Non-Dentist Practitioners

Contractor shall develop and maintain policies and procedures that ensure that the credentials of non-dentists have been verified in accordance with State requirements applicable to the provider category.

8. Changes to Credentialing and Revalidation Policies

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

M. Dental Records

1. General Requirement

Contractor shall ensure that appropriate dental records for Members, pursuant to 28 CCR 1300.80(b)(4) and 42 USC 1396a(w), shall be available to providers at each encounter in accordance with 28 CCR 1300.67.1(c).

2. Dental Records

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

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

3. On-Site Dental Records

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

4. Member Dental Record

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

- a. Member identification on each page; personal/biographical data in the record.
 - b. Member's preferred language (if other than English) prominently noted in the record, as well as the request or refusal of language/interpretation services.
 - c. All entries dated and author identified; for Member visits, the entries shall include at a minimum, the subjective complaints, the objective findings, and the diagnosis and treatment plan.
 - d. A complete record of all services rendered.
 - e. A complete medical and dental history, including prominent notation in the record of allergies and adverse reactions. The medical history is to be updated at every visit, with a notation to that effect in the record.
 - f. All informed consent documentation.
5. All emergency care provided by the contracted provider or non-contracting provider.
6. Consultations, referrals (dental and medical), specialists' reports.
7. Oral health instruction.
8. Record Maintenance

Unless a different period of time is otherwise required by law, Contractor shall maintain or cause to be maintained all records necessary to verify information and reports required by statute, regulation or contractual obligation for five (5) years from the date of submission of the information or reports. Such records include, but are not limited to, working papers used in the preparation of reports to DHCS, financial documents, medical or dental records, and prescription files.

N. Evaluation of Contractor Compliance/Corrective Action Plan (CAP)

DHCS will evaluate Contractor's overall compliance with contract requirements monthly. Contractor shall ensure that a corrective action plan is developed to correct cited deficiencies and that corrections are completed and verified within the established

guidelines as specified in the dental managed care All Plan Letter to be executed at contract effective date. If Contractor fails to correct cited deficiencies as specified in the All Plan Letter, then the DHCS reserves the right to halt all new enrollment to the plan until such time as the deficiencies have been corrected and approved by the Department.

EXHIBIT A, ATTACHMENT 6
PERFORMANCE MEASURES AND BENCHMARKS**A. Determination of Performance**

DHCS has established performance measures for evaluation of dental health plan performance. These performance measures will be used to monitor plan utilization and services of Members. Contractor's utilization performance will be evaluated based upon eleven (11) separate measures. DHCS will assign the point values indicated in Column C in the tables below to the annual utilization rates achieved on each measure and each age group within each measure. The point values will be totaled and a portion of the withheld ten (10) percent of the monthly Capitation Payment will be paid to the Contractor according to the following schedule:

Total Points	Portion of 10% Withhold Paid to Contractor
0-150	0%
155-270	25%
275-390	50%
395-410	75%
415-570	100%

B. Bonus Payment

DHCS will award Contractor a bonus payment of up to five (5) percent of the monthly Capitation Payment for exceptional performance on the selected utilization measures and age groups indicated in Column D in the tables below, according to the following schedule:

Total Points	Portion of 5% Bonus Paid to Contractor
0-100	0%
120-180	25%
200-280	50%
300-380	75%
400-480	100%

C. Performance Measures

1. The eleven (11) performance measures are as follows:

- a. Annual Dental Visits – Percentage of Members who had at least one (1) dental visit during the measurement year.

Calculation

Numerator: Number of Members enrolled in the same plan during the measurement year for at least ninety (90) continuous days who received any dental procedure (D0100-D9999) during that period.

Denominator: Number of Members enrolled in the same plan during the measurement year for at least ninety (90) continuous days.

Benchmarks

A	B	C	D
Age Group	Benchmark (BM)	Points if Meet or Exceed BM	Points for Bonus if Exceed BM by > 5 Percentage Points
0-3	30.3	10	20
4-5	66.6	10	20
6-8	64.1	5	
9-11	61.4	5	
12-14	54.9	5	
15-18	48.6	5	
19-20	33.7	5	
2-18	56.5	5	

- b. Continuity of Care – percentage of Members continuously enrolled in the same plan for two (2) years with no gap in coverage who received a comprehensive oral evaluation or a prophylaxis in both the year prior to the measurement year and in the measurement year.

Calculation

Numerator: Number of Members in the denominator who also received a comprehensive or periodic oral evaluation (D0120, D0150) or a prophylaxis (D1110, D1120) in the measurement year.

Denominator: Number of Members continuously enrolled in the same plan for two (2) years with no gap in coverage who received a comprehensive oral evaluation (D0120, D0150) or a prophylaxis (D1110, D1120) in the year prior to the measurement year.

Benchmarks

A	B	C	D
Age Group	Benchmark (BM)	Points if Meet or Exceed BM	Points for Bonus if Exceed BM by > 5 Percentage Points
0-3	69.6	10	20
4-5	71.4	10	20
6-8	68.1	5	

9-11	65.9	5	
12-14	62.3	5	
15-18	59.6	5	
19-20	52.8	5	
0-18	65.2	5	

- c. Use of Preventive Services – percentage of Members who received any preventive dental service during the past year.

Calculation

Numerator: Number of Members enrolled in the same plan during the measurement year for at least ninety (90) continuous days who received any preventive dental service (D1000-D1999) in the measurement year.

Denominator: Number of Members enrolled in the same plan during the measurement year for at least ninety (90) continuous days.

Benchmarks

A	B	C	D
Age Group	Benchmark (BM)	Points if Meet or Exceed BM	Points for Bonus if Exceed BM by > 5 Percentage Points
0-3	22.3	10	20
4-5	55.4	10	20
6-8	55.2	5	
9-11	52.6	5	
12-14	47.0	5	
15-18	38.9	5	
19-20	24.9	5	
0-18	43.5	5	

- d. Use of Sealants – percentage of Members ages six (6) through nine (9) and ten (10) through fourteen (14) enrolled in the same plan during the measurement year for at least ninety (90) continuous days who received a dental sealant on at least one (1) permanent molar tooth.

Calculation

Numerator: 1) Number of Members ages six (6) through nine (9) enrolled in the same plan during the measurement year for at least (90) continuous days who received a dental sealant (D1351) on a permanent first molar (Tooth Number = 3, 14, 19, 30), and 2) Number of Members ages ten (10) through fourteen (14) enrolled in the same plan during the measurement year for at least (90) continuous days who received a dental sealant (D1351) on a permanent second molar (Tooth Number = 2, 15, 18, 31), respectively.

Denominator: Number of Members ages six (6) through nine (9) and ten (10) through fourteen (14), respectively, enrolled in the same plan during the measurement year for at least (90) continuous days.

Benchmarks

A	B	C	D
Age Group	Benchmark (BM)	Points if Meet or Exceed BM	Points for Bonus if Exceed BM by > 5 Percentage Points
6-9	19.2	5	10
10-14	14.2	5	10

- e. Sealant to Restoration Ratio (Surfaces) – The ratio of occlusal surfaces of permanent first and second molars receiving dental sealant to those receiving restoration among Members ages six (6) through nine (9) and ten (10) through fourteen (14) enrolled in the same plan during the measurement year for at least (90) continuous days.

Calculation

Numerator: Number of occlusal surfaces of permanent first molars (Tooth Number = 3, 14, 19, 30) in six (6) through nine (9) and ten (10) through fourteen (14) year-olds and of permanent second molars (Tooth Number = 2, 15, 18, 31) in ten (10) through fourteen (14) year-olds receiving dental sealant (D1351) among Members in those age groups enrolled in the same plan during the measurement year for at least (90) continuous days.

Denominator: Number of occlusal surfaces of permanent first molars (Tooth Number = 3, 14, 19, 30) in six (6) through nine (9) and ten (10) through fourteen (14) year-olds and of permanent second molars (Tooth Number = 2, 15, 18, 31) in ten (10) through fourteen (14) year-olds receiving a restoration (D2000-D2999)

among Members in those age groups enrolled in the same plan during the measurement year for at least (90) continuous days.

Benchmarks

A	B	C	D
Age Group	Benchmark (BM)	Points if Meet or Exceed BM	Points for Bonus if Exceed BM by > 5 Percentage Points
6-9	3.57	5	10
10-14	1.74	5	10

- f. Treatment/Prevention of Caries – percentage of Members who received either treatment for caries or a caries-preventive procedure during the past year.

Calculation

Numerator: Number of Members enrolled in the same plan during the measurement year for at least (90) continuous days who received a treatment for caries (D2000-D2999) or a caries-preventive procedure (D1203-D1206, D1310, D1330, D1351) during the past year.

Denominator: Number of Members enrolled in the same plan during the measurement year for at least (90) continuous days.

Benchmarks

A	B	C	D
Age Group	Benchmark (BM)	Points if Meet or Exceed BM	Points for Bonus if Exceed BM by > 5 Percentage Points
0-3	10.0	10	20
4-5	33.1	10	20
6-8	40.7	5	
9-11	36.1	5	
12-14	34.0	5	
15-18	27.8	5	
19-20	17.5	5	
0-18	28.2	5	

- g. Exams/Oral Health Evaluations - The percentage of Members who received a comprehensive or periodic oral health evaluation or, for Members under three (3) years of age, who received an oral evaluation and counseling with the primary care giver, during the past year.

Calculation

Numerator: Number of Members enrolled in the same plan during the measurement year for at least (90) continuous days who received a comprehensive or periodic exam (D0120 or D0150) or, for Members under three (3) years of age, who received an oral evaluation and counseling with the primary caregiver (D0145), during the past year.

Denominator: Number of Members enrolled in the same plan during the measurement year for at least (90) continuous days.

Benchmarks

A	B	C	D
Age Group	Benchmark (BM)	Points if Meet or Exceed BM	Points for Bonus if Exceed BM by > 5 Percentage Points
0-3	23.9	10	20
4-5	56.7	10	20
6-8	55.5	5	
9-11	53.0	5	
12-14	47.5	5	
15-18	40.6	5	
19-20	27.8	5	
0-18	44.5	5	

- h. Overall Utilization of Dental Services – percentage of Members continuously enrolled for one (1), two (2), and three (3) years who received any dental service during those periods

Calculation

Numerator: Number of Members continuously enrolled in the same plan for one (1), two (2), and three (3) years with no break in eligibility who received any dental service (D0100-D9999) during those periods.

Denominator: Number of Members continuously enrolled in the same plan for one (1), two (2), and three (3) years, respectively.

Note: For plans enrolling new Members beginning in 2012, this measure will not come into play for those Members until the end of the first full year, although it can still be applied for existing Members who have remained in a plan for the requisite number of years.

Benchmarks

A	B			C	D
Age Group	Benchmark (BM)			Points if Meet or Exceed BM	Points for Bonus if Exceed BM by > 5
	Yr 1	Yr 2	Yr 3		

					Percentage Points
0-3	31.4	47.6	62.7	10	20
4-5	66.9	79.4	83.5	10	20
6-8	64.7	79.2	85.4	5	
9-11	61.4	77.4	85.0	5	
12-14	55.3	71.8	80.5	5	
15-18	48.1	64.0	72.5	5	
19-20	34.3	50.1	59.7	5	
0-18	53.1	70.9	81.2	5	

- i. Usual Source of Care -- Percentage of Members who received any dental service each year for two (2) consecutive years

Calculation

Numerator: Number of Members continuously enrolled in the same plan for two (2) consecutive years who received at least one (1) dental service in each of those years.

Denominator: Number of Members continuously enrolled in the same plan for two (2) consecutive years

Benchmarks

A	B	C	D
	Benchmark (BM)	Points if Meet or Exceed BM	Points for Bonus if Exceed BM by > 5 Percentage Points
0-3	11.8%	10	20
4-5	38.0%	10	20
6-8	45.9%	5	
9-11	42.0%	5	
12-14	36.5%	5	
15-18	31.2%	5	
19-20	22.3%	5	
0-18	34.1%	5	

- j. Use of Dental Treatment Services – Percentage of Members who received any dental treatment service during the past year.

Calculation

Numerator: Number of Members enrolled in the same plan during the measurement year for at least (90) continuous days who received any dental treatment service (D2000-D9999) in the measurement year.

Denominator: Number of Members enrolled in the same plan during the measurement year for at least (90) continuous days.

Benchmarks

A	B	C	D
	Benchmark (BM)	Points if Meet or Exceed BM	Points for Bonus if Exceed BM by > 5 Percentage Points
0-3	9.0%	10	20
4-5	33.1%	10	20
6-8	38.4%	5	
9-11	34.3%	5	
12-14	29.3%	5	
15-18	28.1%	5	
19-20	21.3%	5	
0-18	27.3%	5	

- k. Preventive Services to Fillings – Percentage of Members who received one (1) or more fillings in the measurement year who also received preventive services (topical fluoride application, sealant, preventive resin restoration, education) in the measurement year.

Calculation

Numerator: Number of Members enrolled in the same plan during the measurement year for at least (90) continuous days who received one (1) or more fillings (D200-D2999) in the measurement year and who also received one (1) or more topical fluoride applications (D1203, D1204 or D1206), dental sealants (D1351), preventive resin restorations (D1352) or education to prevent caries (D1310 or D1330) in the measurement year.

Denominator: Number of Members enrolled in the same plan during the measurement year for at least (90) continuous days, who received one (1) or more fillings (D2000-D2999) in the measurement year.

Benchmarks

A	B	C	D
	Benchmark (BM)	Points if Meet or Exceed BM	Points for Bonus if Exceed BM by > 5 Percentage Points
0-3	71.7%	10	20
4-5	66.6%	10	20
6-8	72.0%	5	
9-11	71.2%	5	
12-14	62.0%	5	
15-18	41.2%	5	
19-20	25.8%	5	
0-18	62.3%	5	

- Contractors will submit all the necessary encounter data to capture the eleven (11) measures. The data must be submitted within six (6) months of the date of service.
- DHCS will monitor the performance measures on a monthly basis. Contractor will be notified if DHCS identifies a problem with the Contractor's performance or feels that the Contractor is in jeopardy of not achieving the benchmark at their annual review.

B. Performance Measures and Benchmarks

Each performance measure will have approved DHCS benchmarks. These performance measures and benchmarks will be reevaluated each year. DHCS will notify Contractor at the beginning of each measurement year of the new required performance measures

and benchmarks. Contractor shall meet or exceed the benchmark for each measure and/or any other performance measure established by DHCS.

C. Online Posting of Utilization Data

Upon completion of DHCS' annual evaluation of performance measures, DHCS will publish all results of the Contractor's performance on the Denti-Cal website (www.denti-cal.ca.gov).

**EXHIBIT A, ATTACHMENT 7
UTILIZATION MANAGEMENT**

A. Utilization Management (UM) Program

Contractor shall develop, implement, and continuously update and improve, a UM program that ensures appropriate processes are used to review and approve the provision of medically necessary dental covered services as identified in the Medi-Cal Dental Manual of Criteria. Contractor is responsible to ensure that the UM program includes:

1. Qualified staff responsible for the UM program.
2. The separation of dental care decisions from fiscal and administrative management to assure dental care decisions will not be unduly influenced by fiscal and administrative management.
3. Allowances for a second opinion from a qualified dental professional at no cost to the Member.
4. Established criteria for approving, modifying, deferring, or denying requested services. Contractor shall utilize evaluation criteria and standards to approve, modify, defer, or deny services. Contractor shall document the manner in which providers are involved in the development and or adoption of specific criteria used by the Contractor.
5. Communications to dental providers of the procedures and services that require prior authorization and ensure that all contracting dental providers are aware of the procedures and timeframes necessary to obtain prior authorization for these services.
6. An established specialty referral system to track and monitor referrals requiring prior authorization through the Contractor. The system shall include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals.

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

7. The integration of UM activities into the Quality Improvement System (QIS), including a process to integrate reports on review of the number and types of **grievances and** appeals, denials, deferrals, and modifications to the appropriate QIS staff.
8. Procedures for continuously reviewing the performance of dental care personnel, the utilization of services and facilities, and cost.

These activities shall be done in accordance with Health and Safety Code Section 1367.1 and 28 CCR 1300.70(a)(3) and (c).

9. In accordance with 42 CFR 438.210(e), and consistent with 42 CFR 438.3(i) and 42 CFR 422.208, compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any Member.

B. ~~Pre-Authorizations~~ and Review Procedures

Contractor shall ensure that its ~~pre-authorization~~ procedures for processing prior-authorization, continuing, and retrospective requests for services are in accordance with the Medi-Cal Dental policy and procedures as described in the Medi-Cal Dental Manual of Criteria, and Health and Safety Code Section 1367.01(h). ~~and meet the following minimum requirements:~~ The following minimum requirements must be met:

1. Qualified dental professionals supervise review decisions, and a qualified dentist will review all denials.
2. There is a set of written criteria or guidelines for Utilization Review that is based on the dental standard of care, is consistently applied, regularly reviewed, and updated.
3. Reasons for decisions are clearly documented.
4. Notification to Members regarding denied, deferred or modified referrals is made as specified in Exhibit A, Attachment 14, Member Services. There shall be a well-publicized **grievances and** appeals proceduress for both providers and Members.
5. Decisions and appeals **concerning adverse benefit determinations and grievances,** are made in a timely manner and are not unduly delayed for dental conditions requiring time sensitive services, **in accordance with Attachment 15.**
6. Prior Authorization requirements shall not be applied to emergency services.
7. Records, including any Notice of Action, shall meet the retention requirements described in Exhibit E, Additional Provisions, Provision 20, Audit.
8. The requesting provider is notified of any decision to deny, approve, modify, or delay a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. Notification must always be sent to the provider in writing. Verbal notice may also be given to the provider, but must be followed up by the written notification. **Contractor and its subcontractors must consult with the requesting provider for medical services when appropriate.**

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

C. Timeframes for Dental Authorization

1. Emergency Care: No prior authorization required, following the reasonable person standard to determine that the presenting complaint might be an emergency.

Emergency care must be readily available and accessible within the service area twenty-four (24) hours a day, seven (7) days a week.

2. Routine authorizations: Within five (5) business days from the receipt of the information that is reasonably necessary to render a decision (these are requests for specialty service, cost control purposes, out-of-network services not otherwise exempt from prior authorization) in accordance with Health and Safety Code Section 1367.01(h)(1), or any future amendments thereto, but, no longer than 14 calendar days from the receipt of the request. The decision may be deferred and the time limit extended an additional 14 calendar days only where the Member or the Member's provider requests an extension, or the Contractor can provide justification upon request by the State for the need for additional information and how it is in the Member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such. **If Contractor extends the timeframe for providing a Notice of Adverse Benefit Determination for standard authorizations decisions beyond 14 days, Contractor must give the member written notice of the reason for the extension and inform the member of their right to file a grievance if he or she disagrees with the decision. If Contractor extends the 14 calendar day notice of adverse benefit determination timeframe for standard authorization decisions that deny or limit services, it must issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.**
3. Expedited authorizations: **In accordance with 42 CFR 438.210(d), F**or requests in which a provider indicates, or the Contractor determines that, following the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make an expedited authorization decision and provide notice as expeditiously as the Member's health condition requires and no later than **72 hours three (3) business days** after receipt of the request for services. The Contractor may extend the **72 hour three (3) business days'** time period by up to 14 calendar days if the Member requests an extension, or if the Contractor justifies, to the DHCS upon request, a need for additional information and how the extension is in the Member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.
4. **Contractor shall give member notice when service authorization decisions are not reached within the applicable timeframes for either standard or expedited service authorizations on the date that the applicable timeframes expire.**

D. Review of Utilization Data

Contractor shall include within the UM program mechanisms to detect both under- and over-utilization of dental services. Contractor shall suspend all new enrollments for a provider who does not meet the thresholds of utilization. Reinstatement of enrollment may proceed once thresholds are met. Contractor's internal reporting mechanisms used

to detect Member utilization patterns shall be reported to DHCS no later than thirty (30) calendar days after the beginning of each calendar year.

Contractor shall submit self-reported monthly utilization data by Primary Care Dentist service site as determined by DHCS in an All Plan Letter. The report shall be submitted thirty (30) calendar days after the end of each reporting month.

E. Delegating UM Activities

Contractor may delegate UM activities. If Contractor delegates these activities, Contractor shall comply with Exhibit A, Attachment 5, Quality Improvement System, Provision F, Delegation of Quality Improvement Activities.

**EXHIBIT A, ATTACHMENT 8
PROVIDER NETWORK**

A. Network Capacity

Contractor shall submit a complete provider network including provider compensation agreements to DHCS for approval thirty (30) days after contract effective date that is adequate to provide required covered services for Members in the service area. Contractor will increase the capacity of the network as necessary to accommodate enrollment growth.

B. Provider to Member Ratios

1. Contractor shall be in accordance with 28 CCR 1300.67.2 Accessibility of Services, and submit the methodology used to monitor Member ratio to DHCS for approval prior to the commencement of the Operations Period.
2. Contractor shall assess each Primary Care Dentist's enrollment capacity. Enrollment capacity shall be assessed by Contractor using factors including, but not limited to:
 - a. Appointment availability.
 - b. Use of professional and ancillary dental personnel including, but not limited to, Registered Dental Assistants and Registered Dental Hygienists.
 - c. Specific "office efficiencies" including, but not limited to, the number of available operators and extended office hours;
 - d. Existing number of Members;
 - e. Existing number of active (non-Member) patients; and
 - f. Full time equivalent dentists, hygienists, and dental assistants devoted to clinical activities.

C. Emergency Services

Contractor shall ensure that a Member with an emergency dental condition will be seen immediately and emergency services shall be available and accessible within the service area on a 24-hours-a-day, 7-days-a-week basis.

D. Specialists

Contractor shall provide accessibility to required specialists who are certified or eligible for certification by the appropriate specialty board, through contracting or referral. Contractor shall maintain adequate numbers and types of specialists within their network to accommodate the need for specialty care. Contractor shall provide a record/tracking

mechanism for each authorized, denied, or modified referral. In addition, Contractor shall offer second opinions by specialists to any Member upon request.

Contractor shall actively conduct outreach activities to subcontract with Pediatric Dentists in the service area, including specific attempts to recruit them as Primary Care Dentists and include them as part of the Contractor's provider network. The Contractor must submit a quarterly detailed written report to DHCS highlighting the activities associated with active recruitment. This report shall be submitted to DHCS within fifteen (15) days following the end of the quarter.

E. Time and Distance Standard

Contractor shall maintain a network of Primary Care Dentists that are located within thirty (30) minutes or ten (10) miles of a Member's residence unless the Contractor has a DHCS approved alternative time and distance standard.

F. Adequate Facilities and Personnel

Contractor shall demonstrate the continuous availability and accessibility of adequate numbers of service locations, and professional and ancillary dental personnel to provide covered services. **Adequate facilities and personnel shall be sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of Members in the service area, and as prescribed in federal and state law.**

G. Changes to Provider Network Report

Contractor shall submit to DHCS monthly in a format specified by DHCS in Exhibit A, Attachment 19, Deliverable Template, a report identifying deletions and additions in the provider network.

1. The report shall identify provider deletions and additions and the resulting impact to:
 - a. Geographic access for the Members.
 - b. Cultural and linguistic services including provider and provider staff language capability.
 - c. The number of Members assigned to each Primary Care Dentist.
 - d. The network providers who are not accepting new patients.
2. Contractor shall submit the report within fifteen (15) calendar days following the end of the month.

H. Plan Provider Network

Contractor shall submit to DHCS biannually or upon DHCS' request, in a format specified in Exhibit A, Attachment 19, Deliverable Template a report containing the names of all direct subcontracting providers, specialists and provider groups including

FQHCs and RHCs. The report must be sorted by subcontractor type, indicating the county or counties in which Members are served. In addition, the report should also indicate where relationships or affiliations exist between direct and indirect subcontractors. The report shall be submitted monthly, no later than fifteen (15) calendar days following the end of the reporting month or within ten (10) calendar days of DHCS' written request.

Regarding the Contractor's provider network responsibilities, the Contractor shall:

1. **Maintain and monitor a network of appropriate providers that is supported by written provider agreements and is sufficient to provide adequate access to all services covered under the contract for all Members, including those with limited English proficiency or physical or mental disabilities.**
2. **Provide for a second opinion from a network provider, or arrange for the Member to obtain a second opinion outside the network, at no cost to the Member.**
3. **If the Contractor's provider network is unable to provide necessary services, covered under the contract, to a particular Member, the Contractor must adequately and timely cover these services out-of-network for the Member, for as long as the Contractor's provider network is unable to provide them.**
4. **Require out-of-network providers to coordinate with the Contractor for payment and ensures the cost to the Member is no greater than it would be if the services were furnished within the network.**
5. **Demonstrate that its network providers are credentialed as required by 42 CFR § 438.214.**

I. Ethnic and Cultural Composition

Contractor shall ensure that the composition of Contractor's provider network meets the ethnic, cultural, and linguistic needs of Contractor's Members on a continuous basis. **Contractor shall collaborate and participate in DHCS' efforts to promote the delivery of services in a culturally competent manner to all Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity.**

J. Subcontracts

Contractor may enter into subcontracts with other entities in order to fulfill the obligations of the contract. In doing so, Contractor shall meet the subcontracting requirements as stated in 22 CCR 53250, as well as those specified in this contract. Contractor shall

remain accountable for all functions and responsibilities that are delegated to subcontractors.

1. Laws and Regulations

All subcontracts shall be in writing and in accordance with the requirements of the Health and Safety Code Section 1340 et seq.; 28 CCR 1300.43.12.; Welfare and Institutions Code Section 14200 et seq., **42 CFR § 438.608**, and 22 CCR 53900 et seq.; and applicable Federal and State laws and regulations.

2. Subcontract Requirements

Each subcontract shall contain:

- a. Specification of the services to be provided by the subcontractor.
- b. Specification that the subcontract shall be governed by and construed in accordance with all laws and applicable regulations governing this contract, **including the timely and adequate notice of benefit determinations requirements as identified under Exhibit A, Attachment 7, if such responsibilities are carried out by the Subcontractor.**
- c. Specification of the term of the subcontract, including the beginning and ending dates as well as methods of extension, renegotiation and termination.
- d. Language comparable to Exhibit A, Attachment 10, Provider Compensation Arrangements, Provision H, Non-Contracting Emergency Service Providers for those subcontractors at risk for non-contracting emergency services.
- e. Subcontractor's agreement to submit reports as required by Contractor.
- f. Subcontractor's agreement to make all of its books and records, pertaining to the goods and services furnished under the terms of the subcontract, available for inspection, examination or copying:
 - 1) By DHCS, Department of Health and Human Services (DHHS), Department of Justice (DOJ), Department of Managed Health Care (DMHC), **Center for Medicare and Medicaid Services (CMS), Office of Inspector General (OIG) and the Office of the Comptroller General, and any other federal or state entities as requested by DHCS.**
 - 2) At all reasonable times at the subcontractor's place of business or at such other mutually agreeable location in California.
 - 3) In a form maintained in accordance with the general standards applicable to such book or record keeping.

-
- 4) For a term of at least ~~five (5)~~**ten (10)** years from the close of the current State Fiscal Year in which the date of service occurred; in which the record or data was created or applied; and for which the financial record was created.
 - 5) Including all encounter and/or claims data for a period of at least ~~five (5)~~**ten (10)** years.
 - g. Full disclosure of the method and amount of compensation or other consideration to be received by the subcontractor from the Contractor.
 - h. Subcontractor's agreement to maintain and make available to DHCS, upon request, copies of all sub-subcontracts and to ensure that all sub-subcontracts are in writing and require that the Sub-Subcontractor:
 - 1) Make all applicable books and records available at all reasonable times for inspection, examination, or copying by DHCS, DHHS, DOJ, DMHC, **CMS, OIG and the Office of the Comptroller General.**
 - 2) Retain such books and records for a term of at least ~~five (5)~~ **ten (10)** years from the close of the current State Fiscal Year in which the date of service occurred; in which the record or data was created or applied; and for which the financial record was created.
 - i. Subcontractor's agreement to assist Contractor in the transfer of care pursuant to Exhibit E, Additional Provisions, Provision 17, Phase Out Requirements, in the event of contract termination.
 - j. Subcontractor's agreement to assist Contractor in the transfer of care in the event of sub-subcontract termination for any reason.
 - k. Subcontractor's agreement to provide written notification to DHCS within thirty (30) calendar days in the event the agreement with the Contractor is amended or terminated. Written notification is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached.
 - l. Subcontractor's agreement that assignment or delegation of the subcontract will be void unless prior written approval is obtained from DHCS.
 - m. Subcontractor's agreement to hold harmless both the State and Members in the event the Contractor cannot or will not pay for services performed by the subcontractor pursuant to the Subcontract.
 - n. Subcontractor's agreement to timely gather, preserve and provide to DHCS, any records in the subcontractor's possession, in accordance with Exhibit E, Additional Provisions, Provision 26, Records Related to Recovery for Litigation.
 - o. Subcontractor's agreement to provide interpreter services for Members at all provider sites.

-
- p. Subcontractor's right to submit a grievance and Contractor's formal process to resolve provider grievances, **including federal and state laws, including, but not limited, to CFR § 438.404.**
 - q. Subcontractor's agreement to participate and cooperate in the Contractor's Quality Improvement System.
 - r. If Contractor delegates quality improvement activities, subcontract shall include those provisions stipulated in Exhibit A, Attachment 5, Quality Improvement System, Provision F, Delegation of Quality Improvement Activities.
 - s. Subcontractor's agreement to comply with all applicable requirements specified in: this Contract and subsequent amendments, Federal and State laws and regulations, and Medi-Cal Dental Managed Care All Plan Letters (APL).
 - t. Pursuant to Health & Safety Code Section 1261, subcontractor's agreement by any subcontracting or sub-subcontracting health facility, if subcontractor is licensed pursuant to Health & Safety Code Section 1250, to permit a Member to be visited by a Member's domestic partner, the children of the Member's domestic partner, and the domestic partner of the Member's parent or child.
 - u. Subcontractor's agreement to provide Contractor with the disclosure statement set forth in 22 CCR 51000.35, prior to commencing services under the Subcontract.
3. Public Records

Subcontracts entered into by the Contractor and all information received in accordance with this subsection will be public records on file with DHCS, except as specifically exempted in statute. DHCS shall ensure the confidentiality of information and contractual provisions filed with DHCS to the extent they are specifically exempted by statute from disclosure, in accordance with the statutes providing the exemption. The names of the officers and owners of the subcontractor, stockholders owning more than ten (10) percent of the stock issued by the subcontractor and major creditors holding more than five (5) percent of the debt of the subcontractor will be attached to the subcontract at the time the subcontract is presented to DHCS.

K. Review of Subcontracts

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

L. Subcontracts with Federally Qualified Health Centers, Rural Health Clinics and Indian Health Care Providers Service Facilities (FQHC/RHC/IHCP)

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

Subcontracts with FQHCs and IHCPs shall also meet subcontract requirements of Provision J above and reimbursement requirements in Exhibit A, Attachment 10, Provider Compensation Arrangements, Provision G. In subcontracts with FQHCs, IHCPs, and RHCs where a negotiated reimbursement rate is agreed to as total payment, a provision that such rate constitutes total payment shall be included in the subcontract. Contractor shall assign Members to FQHCs, RHCs and IHCPs ~~Indian Health Service Facilities~~.

M. Nondiscrimination in Provider Contracts

Pursuant to 42 CFR 438.12 Contractor shall not discriminate in the participation, reimbursement, or indemnification of any provider who is acting within the scope of practice of his or her license or certification under applicable State law, solely on the basis of that license or certification. If the Contractor declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision. Contractor's provider selection policies must not discriminate against providers that serve high-risk populations or specialize in conditions requiring costly treatment. This section shall not be construed to require Contractor to contract with providers beyond the number necessary to meet the needs of Contractor's Members; preclude Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or preclude Contractor from establishing measures that are designed to maintain quality of services and control costs and are consistent with Contractor's responsibilities to Members.

**EXHIBIT A, ATTACHMENT 9
PROVIDER RELATIONS****A. Exclusivity**

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

B. Provider Grievances

Contractor shall have a formal process to accept, acknowledge, and resolve provider ~~grievances~~ appeals. A provider of dental services may submit to Contractor ~~an grievance~~ an appeal concerning the authorization or denial of a service, denial, deferral, or modification of a prior authorization request on behalf of a Member and Contractor shall resolve the ~~grievance~~ appeal within thirty (30) calendar days or document reasonable efforts to resolve the ~~grievance~~ appeal; or the processing of a payment or non-payment of a claim by the Contractor. This process shall be communicated to contracting, subcontracting and non-contracting providers.

C. Non-Contracting, Non-Emergency Provider Communication

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

D. Provider Manual

Contractor shall issue a provider manual and updates to the providers of Medi-Cal dental services. The manual and updates shall serve as a source of information to dental providers regarding Medi-Cal dental services, policies and procedures, statutes, regulations, telephone access and special requirements regarding the Medi-Cal Dental Managed Care program.

Contractor is required to inform providers and subcontractors, at the time they enter into a contract, about Member grievance, appeal, and State Fair Hearing procedures and timeframes as specified in 42 CFR 438.400 through 42 CFR 438.424 and described in the Grievance and Appeals section including:

1. Member's right to **request a State Fair Hearing after the Contractor has made a determination on a Member's appeal which is adverse to the Member;**
2. Member's right to file grievances and appeals and their requirements and timeframes for filing;
3. Availability of assistance **to the Member with** filing **grievances and appeals;**

4. Toll-free numbers to file oral grievances and appeals; and
5. Member's right to request continuation of benefits that the Contractor seeks to reduce or terminate during an appeal or State Fair Hearing filing, if filed within the allowable timeframes, although the Member may be liable for the cost of any continued benefits while the appeal or State Fair Hearing is pending if the final decision is adverse to the Member; and,

6. All provisions of Exhibit A, Attachment 7, Section B.

E. Provider Training

Contractor shall ensure that all providers receive training regarding the Medi-Cal Dental Managed Care program in order to operate in full compliance with the contract and all applicable Federal and State statutes and regulations. Contractor shall ensure that provider training relates to Medi-Cal Dental Managed Care services, policies, procedures and any modifications to existing services, policies or procedures. Training shall include methods for sharing information between Contractor, provider, Member and/or other healthcare professionals. Contractor shall conduct training for all providers within ten (10) business days after the Contractor places a newly contracted provider on active status. Contractor shall ensure that provider training includes, but is not limited to, information on all Member rights specified in Exhibit A, Attachment 14, Member Services, including the right to full disclosure of dental care information and the right to actively participate in dental care decisions. Contractor shall ensure that ongoing training is conducted when deemed necessary by either the Contractor or DHCS. **The Contractor must provide all providers and subcontractors specific information in-writing about the grievance and appeal system at the time the Contractor enters into a contract with providers or subcontractors.**

F. Prohibited Punitive Action against the Provider

Contractor must ensure that punitive action is not taken against the provider who either requests an expedited resolution or supports a Member's appeal.

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

**EXHIBIT A, ATTACHMENT 10
PROVIDER COMPENSATION ARRANGEMENTS****A. Compensation**

The Contractor shall not enter into any subcontract if the compensation or other consideration which the subcontractor shall receive under the terms of the subcontract is determined by a percentage of the Contractor's payment from the State. This subsection shall not be construed to prohibit subcontracts in which compensation or other consideration is determined on a capitation basis.

All providers, FQHCs, RHCs, Indian Health Service Facilities and specialist's compensation arrangements must be submitted to DHCS prior to start of operations. Any additional provider compensation agreements must be submitted to DHCS within thirty (30) days of effective date. DHCS reserves the right to approve or deny any and all compensation arrangements.

If the Contractor puts a provider/physician group at substantial financial risk for services not provided by the provider/physician group, the Contractor must ensure that the provider/physician group has adequate stop-loss protection.

B. Capitation Payments

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

C. Provider Incentive Plan

Contractor may develop an incentive program for providers. The incentive program must define performance measures, including a measure for preventive services. Contractor must calculate the incentive based upon the percentage of enrolled Medi-Cal Members (ages 0-under 21) that received services. **Contractor must make available to Members, upon request, any provider incentive plans in place.**

Contractor may only operate a provider incentive plan if no specific payment can be made directly or indirectly under a provider incentive plan to a provider or provider group as an incentive to reduce or limit medically necessary services to a Member. Contractor shall obtain pre-approval to implement the incentive program.

D. Claims Processing

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

1. Contractor shall comply with 42 USC 1396a(a)(37) and Health and Safety Code Sections 1371 through 1371.36. Contractor shall be subject to any provider remedies, including interest payments provided for in these sections, if it fails to meet the standards specified in these sections.
2. Contractor shall maintain procedures for prepayment and post payment claims review, including review of data related to provider, Member and covered services for which payment is claimed.
3. Contractor shall maintain sufficient claims processing/tracking/payment systems capability to: comply with applicable State and federal law, regulations and contract requirements, determine the status of received claims, and calculate the estimate for incurred and unreported claims as specified by 28 CCR 1300.77.1 and 1300.77.2.
4. Contractor shall submit claims payment summary reports to DHCS on a quarterly basis as specified in Exhibit A, Attachment 3, Financial Information, Provision B, Financial Audit Reports, Subprovision 5.

E. Prohibited Claims

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

Contractor must provide that its Members are not held liable for any of the following:

- 1. Debts of the organization, in the event of the organization's insolvency,**
- 2. Covered services provided to the Member, for which**
 - a. DHCS does not pay the Contractor; or**
 - b. DHCS, or the Contractor, does not pay the individual or health care provider that furnished the services under a contractual, referral, or other arrangement.**

3. Payments for covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the Member would owe if the Contractor covered the services directly.

F. Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), and Indian Health Care Providers (IHCP) Service Facilities

1. FQHCs, RHCs, ~~Indian Health Service Facilities~~ **IHCPs** Availability and Reimbursement Requirement
 - a. If FQHC, RHC and ~~Indian Health Service Facilities~~ **IHCPs** services are not available in Contractor's provider network or the provider network of another Medi-Cal Dental Managed Care Plan in the service area, Contractor shall reimburse non-contracting FQHCs, RHCs and ~~Indian Health Service Facilities~~ **IHCPs** for services provided to Contractor's Members at a level and amount of payment that is not less than the Contractor makes for the same scope of services furnished by a provider that is not a FQHC, RHC or ~~Indian Health Service Facilities~~ **IHCPs**. Emergency services rendered by a non-contracting FQHC, RHC or ~~Indian Health Service Facilities~~ **IHCP** shall be reimbursed as specified in Provision G of this Attachment.
 - b. If FQHC, RHC or ~~Indian Health Service Facilities~~ **IHCP** services are not available in Contractor's provider network, but are available within any other Medi-Cal Dental Managed Care Plan's provider network in the service area, unless authorized by Contractor, Contractor shall not be obligated to reimburse non-contracting FQHCs, or RHCs or ~~Indian Health Service Facilities~~ for services provided to Contractor's Members. **If services are provided to Indian Members who are eligible to receive services, Contractor shall reimburse non-contracting IHCP Facilities at a level and amount of payment that is no less than the Contractor makes for the same scope of services furnished by a provider that is not a FQHC, RHC or IHCP.** Emergency services rendered by a non-contracting FQHC, RHC or ~~Indian Health Service Facilities~~ **IHCP** shall be reimbursed as specified in Provision H of this attachment.
 - c. **In accordance with 42 CFR 447.56, any Indian Member who is eligible to receive or has received an item or service furnished by an IHCP or through referral under contract health services is exempt from premiums. Indian Members who are currently receiving or have ever received an item or service furnished by an IHCP or through referral under contract health services are exempt from all cost sharing.**
2. Federally Qualified Health Centers/Rural Health Clinics/**Indian Health Care Providers** (FQHC/RHC/**IHCP**) ~~Indian Health Service Facilities~~

Contractor shall submit to DHCS, within thirty (30) calendar days of a request and in the form and manner specified by DHCS, the services provided and the

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

To the extent that **IHCP** ~~Indian Health Service Facilities~~ qualify as FQHCs or RHCs, the above reimbursement requirements shall apply to subcontracts with **IHCP** ~~Indian Health Service Facilities~~.

3. Indian Health **Care Providers (IHCP)** ~~Service Facilities~~

Contractor shall reimburse **IHCPs** ~~Indian Health Service Facilities~~ for dental care services provided to Members who are qualified to receive services from an **IHCP** ~~Indian Health Service Facility~~ according to one of the reimbursement options in 22 CCR 55140(a). Contractor shall reimburse non-contracting Indian Health Service Facilities at the approved Medi-Cal per visit rate for that facility. **Contractor shall make payment to IHCPs in a timely manner as required for payments to practitioners in individual or group practices under 42 CFR § 447.45 and 447.46.**

Contractor shall meet the requirements of Medicaid Fee-for-Service (FFS) timely payment for all Indian Tribe, Tribal Organizations, or Indian/Tribal/Urban (I/T/U) Health providers in its network, including the paying of 90 percent of all clean claims from Providers (i.e. those who are in individual or group practice or who practice in shared health facilities) within 30 days of the date of receipt; and paying 99 percent of all clean claims from practitioners (who are in individual or group practice or who practice in shared health facilities) within 90 days of the date of receipt.

Contractor shall pay IHCPs, which are enrolled in Medi-Cal as FQHCs but are not participating providers of the Contractor, an amount equal to the amount the Contractor would pay an FQHC that is a network provider but is not an IHCP, including any supplemental payment from DHCS to make up the difference between the amount the Contractor pays and what the IHCP FQHC would have received under Medi-Cal Fee-for-Service (FFS).

When an IHCP is not enrolled in Medi-Cal as an FQHC, regardless of whether it participates in the network of the Contractor, it has the right to receive its applicable encounter rate published annually in the Federal Register by IHS, or in the absence of a published encounter rate, the amount it would receive if the services were provided under the Medi-Cal state plan's FFS payment methodology.

Contractor shall demonstrate that there are sufficient IHCPs participating in the provider network to ensure timely access to services available under the contract from such providers for Indian Members who are eligible to receive services.

Contractor shall pay IHCPs, whether participating or not, for covered services provided to Indian Members, who are eligible to receive services at a negotiated rate between the Contractor and IHCP or, in the absence of a negotiated rate, at a rate not less than the level and amount of payment the Contractor would make for the services to a participating provider that is not an IHCP.

Indian Members are permitted to obtain covered services from out-of-network IHCPs from whom the Member is otherwise eligible to receive such services. Contractor must permit an out-of-network IHCP to refer an Indian Member to a network provider.

G. Non-Contracting Emergency Service Providers

1. Contractor shall pay for emergency services received by a Member from non-contracting providers. Payments to non-contracting providers shall be for the treatment of the emergency dental condition, including medically necessary dental covered services rendered to a Member to the extent necessary for the Member's condition to be stabilized to sufficiently permit referral in accordance with instructions from Contractor. The non-contracting provider treating the Member's emergency dental condition is responsible for determining the extent of treatment necessary to sufficiently stabilize the Member for referral, and that determination is binding on the Contractor. Emergency services shall not be subject to prior authorization by Contractor.
2. At a minimum, Contractor must reimburse the non-contracting emergency provider for dental services at the lowest level of emergency evaluation, unless a higher level is clearly supported by documentation, and for diagnostic services such as radiology. Absent a separate contract between Contractor and the non-contracting provider stating otherwise, the non-contracting provider must accept as payment in full no more than the amounts (less any payments for indirect costs of medical education and direct costs of graduate medical education) that it could collect if the Member received medical assistance under Fee-For-Service Medi-Cal.

3. For all non-contracting providers, reimbursement by Contractor, or by a subcontractor who is at risk for out-of-plan emergency dental services, for properly documented claims for services rendered by a non-contracting provider, who is enrolled in the Medi-Cal Dental program (Denti-Cal), pursuant to this Provision shall be made in accordance with Provision D, Claims Processing, above, and 42 USC 1396u-2(b)(2)(D).
4. Contractor shall not refuse to cover reimbursement for emergency dental services rendered by a non-contracting provider based on the provider of emergency services not notifying the Member's Primary Care Dentist or Contractor of the Member's screening and treatment within ten (10) calendar days of presentation for emergency. Contractor shall not limit what constitutes an emergency dental condition solely on the basis of lists of diagnoses or symptoms.
5. **Contractor may not deny payment for treatment when a representative of the Contractor instructs the Member to seek emergency services. Contractor may not hold a Member who has an emergency condition liable for subsequent screening and treatment needed to diagnose the specific condition or stabilize the Member.**
- ~~6.5.~~ Disputed emergency services claims may be submitted to DHCS, Office of Administrative Hearings and Appeals, 1029 J Street, Suite 200, Sacramento, California, 95814 for resolution under the provisions of Welfare and Institutions Code Section 14454 and 22 CCR 53620 et. seq. except Section 53698. Contractor agrees to abide by the findings of DHCS in such cases, to promptly reimburse the non-contracting provider within thirty (30) calendar days of the effective date of a decision that Contractor is liable for payment of a claim and to provide proof of reimbursement in such form as the DHCS Director may require. Failure to reimburse the non-contracting provider and provide proof of reimbursement to DHCS within thirty (30) calendar days shall result in liability offsets in accordance with Welfare and Institutions Code Sections 14454(c) and 14115.5, and 22 CCR 53702.

H. Practice Guidelines

1. **Contractor must comply with 42 CFR § 438.236, which requires the Contractor to have a Provider Manual, that is inclusive of reliable clinical evidence or a consensus of providers in the particular field, considers the needs of the Contractor's Members, are adopted, in consultation with contracting health care professionals, and reviewed and periodically updated, as appropriate. Following Department approval, the plan shall develop and disseminate the information.**

- 2. Contractor is responsible for the dissemination of the information to all affected providers and, upon request, dissemination to Members and potential Members.**
 - 3. Contractor decisions for utilization management, Member education, coverage of services, and other areas to which the Provider Manual applies must be consistent with the Provider Manual.**
- I. Special contract provisions related to payment. As requested by DHCS, contractor must comply with 42 CFR § 438.6(c).**
- J. No payments shall be made to a network provider other than by the Contractor for services covered under this contract except when these payments are specifically required to be made by DHCS in Title XIX of the Act, in 42 CFR chapter IV, or when DHCS makes direct payments to network providers for graduate medical education costs approved under the State plan.**

**EXHIBIT A, ATTACHMENT 11
ACCESS AND AVAILABILITY**

A. General Requirement

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

Contractor shall ensure Members access to specialists for medically necessary dental covered services. Contractor shall ensure adequate staff within the service area, including dentists, administrative and other support staff directly and/or through subcontracts, sufficient to assure that dental care services will be provided in accordance with this contract and applicable law.

B. Access Requirements

Contractor shall establish acceptable accessibility standards in accordance with 28 CCR 1300.67.2 and as specified below. Contractor shall submit any revisions, updates and/or changes in writing to DHCS within fifteen (15) calendar days of the change. DHCS will review and approve standards for reasonableness. Contractor shall ensure that contracting providers offer hours of operation that are no less than the hours of operation offered similar to commercial Members or comparable to Medi-Cal Dental Fee-for-Service (FFS), if the provider serves only Medi-Cal Dental Members. Contractor shall communicate, enforce, and monitor providers' compliance with these standards.

1. Appointments

Contractor shall implement and maintain procedures for Members to obtain appointments for routine dental care, emergency services, and specialty referral appointments. Contractor shall also include procedures for follow-up on missed appointments.

2. Waiting Times

Contractor shall develop, implement, and maintain a procedure to monitor waiting times in the provider's offices for scheduled appointments, telephone calls (to answer and return), and time to obtain various types of appointments indicated in Subprovision 1, Appointments, above. The following standards shall apply:

- a. Initial Appointment – within 4 weeks
- b. Routine Appointment (non-emergency) – within 4 weeks
- c. Preventive Dental Care Appointment – within 4 weeks
- d. Specialist Appointment – within 30 business days from request **for adult Members, and within 30 calendar days from request for child Members**
- e. Emergency Appointment – within 24 hours from the request for appointment

Patient sign-in forms shall be maintained in order to document any time beyond the scheduled appointment time spent by the Member in provider office waiting area.

3. Timely Access

Contractor shall survey, within a year's time, all Primary Care Dentists on the average amount of time it takes for Members to obtain initial appointments, routine appointments, specialist appointments, and emergency appointments. Contractor shall also survey for the number of no show appointments, rescheduled appointments, the availability of interpreter services and an answering service, and the ratio of Members to Primary Care Dentist. Contractor shall submit a Timely Access Report for those Primary Care Dentists surveyed in the reporting quarter in a format specified by DHCS (see Exhibit A, Attachment 20, Deliverable Templates) on a quarterly basis, no later than 30 days after the end of the reporting quarter. **Contractor shall establish mechanisms to ensure compliance by network providers, monitor network providers regularly to determine compliance, and take corrective action in the event that there is a failure to comply by a network provider.**

4. Telephone Procedures

Contractor shall provide 24-hour a day telephone access for Members to Primary Care Dentists, emergency services, and specialists, including access to telephone interpreters.

5. Specialty Services

Contractor shall arrange for the provision of specialty services from specialists outside the network if unavailable within Contractor's network, when it is determined to be medically necessary dental covered services.

Contractor shall submit a Specialty Referral Report in a format specified by DHCS (see Exhibit A, Attachment 20, Deliverable Templates) on a biannual basis, no later than January 31st and July 31st of each calendar year that shows how many referrals were made per month to specialists with the detail for each referral, timeliness of receipt and review, and the result of each referral.

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

Unless prohibited by law, Contractor shall arrange for the timely referral and coordination of covered services to which the Contractor or subcontractor has religious or ethical objections to perform or otherwise support and shall demonstrate ability to arrange, coordinate and ensure provision of services through referrals at no additional expense to DHCS. Should the Contractor elect not to provide, reimburse for, or provide coverage of, a counseling or referral service, the Contract must furnish information about the services it does not cover to DHCS whenever it adopts such a policy during the term of the contract.

D. Emergency Care

Contractor shall ensure that a Member with an emergency dental condition will be seen on an emergency basis and that emergency services will be available and accessible within the service area 24 hours a day, 7 days a week.

Contractor shall cover emergency dental services without prior authorization pursuant to 22 CCR 53216 and 28 CCR 1300.67(g).

E. Changes in Availability or Location of Covered Services

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

F. Access for Disabled Members

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

G. Civil Rights Act of 1964

Contractor shall ensure compliance with Title VI of the Civil Rights Act of 1964 and any implementing regulations (42 USC 2000d, 45 CFR 80) that prohibit recipients of federal financial assistance from discriminating against persons based on race, color, religion, or national origin.

H. Linguistic Services

1. Contractor shall ensure equal access to dental care services for limited English proficient Members through provision of high quality interpreter and linguistic services.
2. Contractor shall comply with 42 CFR 438.10(c) **and 438.10(d)** and ensure that all monolingual, non-English-speaking, or limited English proficient (LEP) Medi-Cal beneficiaries receive 24-hour interpreter services at all key points of contact, as defined in Subprovision 3 of this Provision, either through interpreters or telephone language services.
3. **In accordance with 42 CFR 438.10(d)**, Contractor shall provide, at minimum, the following linguistic services at no cost to Medi-Cal Members:
 - a.** Interpreters, signers, or bilingual providers and provider staff at all key points of contact. These services shall be provided to all Members and not limited to those that speak the threshold or concentration standards languages.
 - b.** Fully translated written informing materials, including but not limited to the **Provider Directories**, Member services guide, **Member enrollee** information, welcome packets, marketing information, and form letters including notice of action letters and grievance acknowledgement and resolution letters. Contractor shall provide translated written informing materials to all monolingual or LEP Members that speak the identified threshold or concentration standard languages. The threshold or concentration languages are identified by DHCS within the Contractor's service area, and by the Contractor in its group needs assessment. **Contractor must make its written materials that are critical to obtaining services, including, at a minimum, provider directories, Member handbooks, appeal and grievance notices, and denial and termination notices, available in the prevalent non-English (also referred to as threshold or concentration) languages in its particular service area.**
 - c.** Referrals to culturally and linguistically appropriate community service programs. **Contractor shall have methods to promote access and delivery of services in a culturally competent manner to beneficiaries, including those with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity. These methods shall ensure that beneficiaries have access to covered services as prescribed in Exhibit A, Attachment 12, that are delivered in a manner that meets their unique needs, including, but not limited to, sexual orientation or gender identity.**

d. Contractor must make written materials available in alternative formats upon request of the potential Member or Member at no cost. Auxiliary aids and services must also be made available upon request of the potential Member or Member at no cost. Written materials must include taglines in the prevalent non-English languages in the state, as well as large print, explaining the availability of written translation or oral interpretation to understand the information provided and the toll-free and TTY/TDY telephone number of the Contractor's member/customer service unit. Large print means printed in a font size no smaller than 18 point. Contractor must make interpretation services available free of charge to each Member. This includes oral interpretation and the use of auxiliary aids such as TTY/TDY and American Sign Language. Oral interpretation requirements apply to all non-English languages, not just those that the State identifies as prevalent.

e. Contractor must notify its Members:

- 1) That oral interpretation is available for any language and written translation is available in prevalent languages;
- 2) That auxiliary aids and services are available upon request and at no cost for Members with disabilities; and
- 3) How to access the services in paragraphs (d)(5)(i) and (ii) of this section.

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

- 1) Use easily understood language and format.
- 2) Use a font size no smaller than 12 point.
- 3) Be available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of Members and Members with disabilities or limited English proficiency.
- 4) Include a large print tagline and information on how to request auxiliary aids and services, including the provision of the materials in alternative formats. Large print means printed in a font size no smaller than 18 point.

g. d- Telecommunications Device for the Deaf (TDD)

TDDs are electronic devices for text communication via a telephone line used when one or more of the parties have hearing or speech difficulties. TDDs are also known as TTY, which are telephone typewriters or teletypewriters, or teletypes in general.

he. Telecommunications Relay Service (711)

The 711-telephone number is the Telecommunications Information Relay Service that connects a hearing impaired person with a specially trained operator who

acts as an intermediary, relaying conversations between hearing persons and persons using a TDD/TTY device.

4. Contractor shall provide translated materials to the following population groups within its service area as determined by DHCS:
 - a. A population group of mandatory Medi-Cal beneficiaries residing in the service area who indicate their primary language as other than English and that meet a numeric threshold of 3,000.
 - b. A population group of mandatory Medi-Cal beneficiaries residing in the service area who indicate their primary language as other than English and who meet the concentration standards of 1,000 in a single ZIP code or 1,500 in two contiguous ZIP codes.
5. Key points of contact include:
 - a. Dental care settings: telephone, advice and urgent care transactions, and encounters with dental care providers including pharmacists.
 - b. Non-medical care setting: Member services, orientations, and appointment scheduling.

I. Section 1557 of the Patient Protection and Affordable Care Act

1. **Section 1557 of the Patient Protection and Affordable Care Act prohibits discrimination against individuals participating in certain health programs or activities based on race, color, national origin, sex, age, or disability. This anti-discrimination clause extends to:**
 - a. **Any health program or activity any part of which receives funding from HHS;**
 - b. **Any health program or activity that HHS administers;**
 - c. **Health Insurance Marketplaces and all plans offered by issuers that participate in those Marketplaces.**

Contractor agrees to be responsible for ensuring that the Contractor, any subcontractors, and providers comply with the non-discrimination clauses.

J. Anti-Discrimination against Gender Identity and Sexual Orientation

Contractor shall ensure its enrollment practices are non-discriminatory in regards to race, color, national origin, sex, sexual orientation, gender identity, or disability. Any policy or practice that has the effect of discriminating based race, color, national origin, sex, sexual orientation, gender identity or disability is federally prohibited.

K. Voluntary Enrollment

Enrollment is voluntary, except in the case of mandatory enrollment programs. The entities must accept individuals eligible for enrollment in the order in which they apply without restriction (unless authorized by CMS), up to the limits set under the contract.

LI. Healthcare Surge Events

Contractor shall develop and implement policies and procedures to mitigate the effects of natural, manmade, or war-caused disasters involving broad healthcare surge events greatly impacting Contractor's health care delivery system. Contractor's policies and procedures shall ensure that Contractor will pro-actively cope with healthcare surge events resulting from such disasters or states of emergency, and shall include but are not limited to protecting **Members enrollees**, if necessary, by keeping covered services available to Members; keeping the revenue stream flowing to providers in order to keep covered services available; transferring Members from provider-to-provider in the event of diminished plan capacity to keep covered services available; and promptly notifying DHCS of the status of the availability and locations of covered services, and/or providers. Contractor shall submit disaster recovery policies and procedures to DHCS no later than thirty (30) calendar days after contract execution for review and approval. Contractor shall submit any revisions, updates and/or changes in writing to DHCS for approval fifteen (15) calendar days prior to implementing the proposed revision, update and/or change.

**EXHIBIT A, ATTACHMENT 12
SCOPE OF SERVICES****A. Covered Services**

Contractor shall provide or arrange for Members all medically necessary dental covered services and other services required in this contract, **in addition to providing assistance to Members as part of the Beneficiary Support System.** Covered services are those services set forth in Welfare and Institutions Code Section 14132(h), 22 CCR 51059, 51307, and 51003, **and the Denti-Cal Manual of Criteria,** unless otherwise specifically excluded under the terms of this contract. ~~Frequency limitations identified may be exceeded based on dental necessity and appropriateness of care, but in no case shall the frequency limitations be more restrictive.~~ **Services shall be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to Members under FFS Medi-Cal.** Contractor shall not arbitrarily deny or reduce the amount, duration, or scope of a required dental service solely because of diagnosis, type of illness, or condition of the beneficiary, **and services should be provided in accordance with the Denti-Cal Manual of Criteria.** **Contractor is allowed to place appropriate limits on a service for the purpose of utilization control, provided the services furnished can reasonably achieve their purpose.**

B. Medically Necessary Dental Covered Services

For purposes of this Contract, the term “medically necessary dental covered services” will include all covered services, as identified in the Medi-Cal Dental Manual of Criteria, that are reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury **as set forth in 22 CCR 51303(a).** **Contractor is responsible for covering services related to the ability for a Member to achieve age-appropriate growth and development, and to attain, maintain, or regain functional capacity.** **“Medically necessary services” shall be no more restrictive than services provided under FFS Medi-Cal, including quantitative and non-quantitative treatment limits, as indicated in state statutes and regulations, the State Plan, and other State policies and procedures.**

When determining the medical necessity of dental covered services for a Medi-Cal beneficiary under the age of 21, “medical necessity” is expanded to include the standards set forth in 22 CCR 51340 and 51340.1.

C. Services for Members under 21 Years of Age

Contractor shall ensure the provision of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services ~~and EPSDT Supplemental dental services~~ for Members under **21 years of age** ~~the age of 21.~~ **EPSDT services include the following:**

-
- 1) Dental services which are provided at intervals which meet reasonable standards of dental practice including the American Academy of Pediatric Dentistry periodicity schedule for dental services for children.
 - 2) Dental services at other such intervals, as medically necessary, to determine the existence of a suspected illness or condition.
 - 3) Dental services that include relief of pain and infections, restoration of teeth, and maintenance of dental health.

For Members under 21 years of age, a service is “medically necessary” if the service meets standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code. Medically necessary dental services shall include diagnostic services, treatment, and other measures to correct or ameliorate defects and physical and mental illness and conditions discovered by screening services, whether or not such services are a covered benefit. Contractor shall ensure any Member materials related to the coverage of EPSDT services accurately reflect this medical necessity standard.

~~Contractor shall inform Members that EPSDT services are available for Members under 21 years of age, provide comprehensive dental screening and prevention services, and provide treatment for all medically necessary dental covered services. Contractor shall also adopt the American Academy of Pediatric Dentistry periodicity schedule for dental services to children, including first visit by first birthday.~~

~~For Members under the age of 21 and in those cases where a provider requests EPSDT supplemental dental services pursuant to 22 CCR 51340 and 51340.1, Contractor shall forward all such requests and associated case documentation to DHCS for review by a DHCS Dental Program Consultant.~~

Contractor at a minimum shall be required to:

- 1) Include relevant language on EPSDT supplemental services from the Denti-Cal provider Handbook in the plan's provider manuals;
- 2) Provide specific training on EPSDT supplemental services to plans' provider network;
- 3) Describe the process to review EPSDT requests, including how the provider and Member will be notified of their disposition.

D. Services for All Members

1. Health Education

- a. Contractor shall implement and maintain a dental health education system that provides the organized programs, services, functions, and resources necessary to deliver dental health education to assist Members to improve their dental health and manage dental disease.

- b. Contractor shall ensure the organized delivery of dental health education programs and services, at no charge for Members, using a variety of educational strategies, methods and materials that are appropriate for the Member population and effective in achieving behavioral change for improved dental health. Contractor shall ensure that all dental health education information and materials are provided to Members at no higher than a 6th grade reading level, unless otherwise approved by DHCS, and are provided in a manner and form that are easily understood and culturally and linguistically appropriate for the intended audience.
- c. Contractor shall provide dental health education programs and services directly and/or through subcontractors that have expertise in delivery of dental health education programs and services.
- d. Contractor shall ensure that Members receive dental health education services as part of preventive services and primary dental health care visits. Contractor shall provide resource information, educational materials and other program resources to assist providers to provide effective dental health education services for Members. Contractor is responsible to assist Primary Care Dentists in the development and delivery of culturally and linguistically appropriate health education interventions and assure provisions for low-literate, illiterate and visually and hearing impaired Members.
- e. Contractor shall adopt and maintain appropriate dental health education program standards/guidelines and policies/procedures. Contractor shall maintain documentation that demonstrates effective implementation of all DHCS health education requirements under this contract.
- f. Contractor shall monitor the performance of subcontractors that deliver dental health education programs and services to Members, and implement strategies to improve performance and effectiveness.
- g. No later than thirty (30) calendar days after the beginning of each calendar year, Contractor shall submit to DHCS documentation on the Contractor's health education programs and services and all materials related to health education for review and approval.

**EXHIBIT A, ATTACHMENT 13
CASE MANAGEMENT AND COORDINATION OF CARE**

A. Case Management Services

Contractor shall provide dental case management to each Member.

Contractor shall maintain procedures for monitoring the coordination of care provided to Members, including but not limited to all medically necessary dental covered services delivered both within and outside the Contractor's provider network.

Each Contractor must implement procedures to deliver care to and coordinate services for all Members. These procedures must meet DHCS requirements and must do the following:

1. Ensure that each Member has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the Member. The Member must be provided information on how to contact their designated person or entity; and
2. Coordinate the services the Contractor furnishes to the Member:
 - a. Between settings of care;
 - b. With the services the Member receives from any other Medi-Cal managed care plan, including both medical and dental managed care;
 - c. With the services the Member receives in Medi-Cal Fee-for-Service delivery systems; and
 - d. With the services the Member receives from community and social support providers.

Contractor shall submit and implement a DHCS approved transition of care policy for individuals transitioning to managed care from FFS, or from one MCO to another, when a Member without continued services would experience serious detriment to their health or put them at risk of hospitalization or institutionalization. Transition policies must be consistent with the requirements in 42 CFR § 438.62(b)(1).

In accordance with 42 CFR § 438.208(b)(5), the Contractor must ensure that each provider furnishing services to Members maintains and shares as appropriate a Member health record in accordance with professional standards.

Contractor shall develop and implement an initial dental health assessment appointment policy that may be fulfilled by an initial appointment with the Member's primary care dentist. This appointment shall be a separate and distinct requirement from the initial health screening policy described in Section C of this Attachment.

B. Out-of-Plan Case Management and Coordination of Care

Contractor shall implement procedures to identify individuals who may need or who are receiving services from out-of-plan providers and/or programs to ensure coordinated service delivery and efficient and effective joint case management for services presented in Provisions C and D below.

C. Initial Health Screening Requirement

1. Contractor shall develop and implement an initial health screening policy, and conduct an initial screening of each new Member using an oral health information form (OHIF), in accordance with 42 CFR § 438.208 (b) and any related APLs issued by DHCS. Consistent with the federal requirement, the Contractor shall submit to DHCS any changes to their initial screening policy within ten (10) calendar days of any changes, and annually no later than thirty (30) days after the first day of every calendar year.
2. Contractor shall make a best effort to conduct an initial screening of each Member's needs, within 90 days of the effective date of enrollment for all new Members, including subsequent attempts if the initial attempt to contact the Member is unsuccessful.
3. Contractor shall share with DHCS or other Contractors serving the member the results of any identification and assessment of that Member's needs to prevent duplication of those activities.

D. Services for Members with Special Health Care Needs

Members with Special Health Care Needs (SHCN) are defined as those who have or are at increased risk for a chronic physical, behavioral, developmental, or emotional conditions and who also require health or related services of a type or amount beyond that required by Members generally. Contractor shall have in

place a SHCN policy in accordance with 42 CFR § 438.208 (c) and any related APLs issued by DHCS.

1. Contractor shall implement mechanisms to comprehensively assess each Member identified as having SHCN, to identify any ongoing special conditions of the Member that require a course of treatment or regular care monitoring.
2. For Members with SHCN that are determined by assessment to need a course of treatment or regular care monitoring, the Contractor shall produce a treatment or service plan that meets the following criteria:
 - a. Approved by the Contractor in a timely manner, if approval is required by the Contractor;
 - b. In accordance with any applicable DHCS quality assurance and utilization review standards; and
 - c. Reviewed and revised upon reassessment of functional need, at least every 12 months, or when the Member's circumstances or needs change significantly or at the request of the Member per 42 CFR §441.301(c)(3).
3. Contractor must have a mechanism in place to allow Members to directly access a specialist as appropriate for the Member's condition and identified needs.

E.G. Services for Children who are under 21 years of age with Special Health Care Needs

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

- ~~1.~~ a. Standardized procedures that include dental care provider training for the identification of CSHCN, at enrollment and on a periodic basis thereafter. The identification, assessment, treatment, and coordination of care for CSHCN shall comply with the requirements of 42 CFR 438.208(b)(3) and (b)(4) and 438.208(c)(2), (c)(3), and (c)(4).
- ~~2.~~ b. Methods for ensuring and monitoring timely access to pediatric specialists, sub-specialists, ancillary therapists, community resources, and specialized equipment and supplies; these may include assignment to a specialist as Primary Care Dentist, standing referrals, or other methods as defined by Contractor.
- ~~3.~~ c. Methods for ensuring that each CSHCN receives a comprehensive oral assessment and development of a written dental treatment plan.
- ~~4.~~ d. Case management or care coordination for CSHCN, including coordination with the child's medical managed care plan for surgicenter or hospital operating room support services for dental services, and with other agencies which provide services for children with special health care needs (e.g. mental health,

substance abuse, Regional Center, CCS, local education agency, child welfare agency);

- ~~5.~~ e. Methods for monitoring and improving the quality and appropriateness of care for CSHCN.

E. D. California Children's Services (CCS)

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

1. Contractor shall develop and implement written policies and procedures for identifying and referring children with CCS eligible conditions to the local CCS program. The policies and procedures shall include, but not be limited to those which:
 - a. Assure that contracting providers are informed about CCS-paneled providers within Contractor's network, and procedures that provide for continuity of care between the contracting providers and CCS providers for CCS-covered conditions.
 - b. Ensure that Contractor continues to provide all medically necessary dental covered services for the Member's CCS eligible condition until CCS eligibility is confirmed.
 - c. Ensure that, once eligibility for the CCS program is established for a Member, Contractor shall continue to provide all medically necessary dental covered services that are unrelated to the CCS eligible condition and shall monitor and ensure the coordination of services between its Primary Care Dentist, the CCS specialty providers, and the local CCS program.

G. E. Provider-Preventable Condition (PPC) Requirements

1. Contractor must comply with 42 CFR § 438.3, which mandates that Contractor require provider identification of PPCs as a condition precedent of payment, as well as the prohibition against payment for PPCs as set forth in 42 CFR § 434.6(a)(12) and 42 CFR § 447.26.
2. Contractor must report all identified PPCs in a form and frequency as specified by DHCS. In order to inform Medi-Cal providers of the latest developments concerning PPC requirements, DHCS has created a one-stop website with current information and links to PPC documents, including the updated PPC reporting form: http://www.dhcs.ca.gov/individuals/Pages/AI_PPC.aspx or as updated by DHCS.

3. Reporting is mandatory under federal law pursuant to 42 CFR § 434.6(a)(12) and 42 CFR § 447.26. A provider must report the occurrence of any PPC in any Medi-Cal patient that did not exist prior to the provider initiating treatment, regardless of whether the provider seeks Medi-Cal reimbursement for services to treat the PPC.
4. A provider shall report any PPC in the manner prescribed by DHCS, which includes completing and submitting the PPC Reporting Form (DHCS 7107). An electronic copy shall be submitted, concurrent to the reporting, to: dmcdeliverables@dhcs.ca.gov, or as updated by DHCS to Contractor through a Dental All Plan letter.
5. Providers must submit the form within five days of discovering the condition and confirming that the patient is a Medi-Cal beneficiary.
6. The contract prohibits the Contractor from making payment to a provider for Provider-Preventable Conditions. Provider-Preventable Condition means a condition occurring in any health care setting that meets the following criteria:
 - a. Is identified in the State plan.
 - b. Has been found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines.
 - c. Has a negative consequence for the beneficiary.
 - d. Is auditable.
 - e. Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

H. Services That May Be Covered By the Contractor

1. A Contractor may cover, for Members, services or settings that are in lieu of services or settings covered under the State plan as follows:
 - a. DHCS determines that the alternative service or setting is a medically appropriate and cost effective substitute for the covered service or setting under the State plan.
 - b. The Member is not required by the Contractor to use the alternative service or setting.

-
- c. The approved in lieu of services are authorized and identified in the Contractors contract, and will be offered to enrollees at the option of the Contractor.

EXHIBIT A, ATTACHMENT 14
MEMBER SERVICES AND BENEFICIARY SUPPORT

A. Members Rights and Responsibilities

1. Member Rights and Responsibilities

Contractor shall develop, implement and maintain written policies that address the Member's rights and responsibilities and shall communicate these to its Members and providers. Contractor must comply with any applicable Federal and state laws that pertain to Member rights and ensure that its employees and contracted providers observe and protect those rights.

a. Contractor's written policies regarding Member rights shall include the following:

- 4) to be treated with respect, giving due consideration to the Member's right to privacy and the need to maintain confidentiality of the Member's medical and dental information.
- 2) to be provided with information about the plan and its services, including covered services, as identified in the Medi-Cal Dental Manual of Criteria.
- 3) to be able to choose a Primary Care Dentist within the Contractor's network.
- 4) to participate in decision making regarding their own dental care, including the right to refuse treatment, and to express preferences about future treatment decisions.
- 5) to ~~voice~~file a grievances, either verbally or in writing, ~~about the organization or the care received~~about any matter other than an adverse benefit determination, which may include, but is not limited to, the quality of care or services provided, aspects of interpersonal relationships between a provider and a Member, such as offensive behavior on part of a provider or an employee, failure to respect the Member's rights regardless of whether remedial action is requested, and to dispute an extension of time proposed by the Contractor to make an authorization decision.
- 6) to have access to the Contractor's grievance and appeal system, according to Exhibit A, Attachment 15.
- 7) to request an appeal, which the Contractor shall review, if an adverse benefit determination is received concerning:
 - a) the denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
 - b) the reduction, suspension, or termination of a previously authorized service;
 - c) the denial, in whole or in part, of payment for a service;
 - d) the failure to provide services in a timely manner, as defined by the State;

-
- e) the failure of the contractor to act within timeframes defined by the State regarding the standard resolution of grievances and appeals;
 - f) or the denial of a request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities.
- 8) to have the notice of adverse benefit determination explain reasons for the adverse benefit determination, including the right of the Member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Member's adverse benefit determination.
- 9) to receive standard resolution of an appeal and notice to the affected parties no later than thirty calendar days from the day the Contractor receives the appeal.
- 10) to receive Member notices and state hearing policies covered in Exhibit A, Attachment 15.
- 11) to request a State fair hearing only after the Member exhausts the appeals process and receives notice that the Contractor is upholding an adverse benefit determination.
- 12) to initiate a State fair hearing if the Contractor fails to adhere to notice and timing requirements, and the Member has exhausted the appeals process. Written notice of the resolution of a grievance or an appeal must meet format and language requirements specified by the State.
- 13) to have the State offer and arrange for an external medical review if the following conditions are met:
- a) the review must be at the Member's option and must not be required before or used as a deterrent to proceeding to the State fair hearing;
 - b) the review must be independent of both the State the Contractor;
 - c) the review must be offered without any cost to the Member;
 - d) the review must not extend any of the timeframes above and must not disrupt continuation of benefits.
- 14) to identify that if the Contractor, or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Contractor must authorize or provide the disputed services promptly and as expeditiously as the Member's health condition requires, but no later than 72 hours from the date it receives notice reversing the determination.
- 15) to identify that for services furnished while the appeal is pending, if the Contractor, or the State fair hearing officer reverses a decision to deny authorization of services, and the Member received the disputed services while the appeal was pending, the Contractor, or the State, must pay for those services, in accordance with State policy and regulations.
- 16) to continue benefits while the Contractor appeal and the state fair hearing are pending. Timely filing of a state hearing occurs within 10

-
- calendar days of the contractor sending the notice of adverse benefit determination or on or before the intended effective date of the contractor's proposed adverse benefit determination.
- 17) to request reinstatement of the Member's benefits, while the appeal or state fair hearing is pending. The benefits must be continued until one of the following occurs:
1. the Member withdraws the appeal or request for state fair hearing;
 2. the Member fails to request a state fair hearing and continuation of benefits within 10 calendar days after the contractor sends the notice of an adverse resolution to the Member's appeal;
 3. a State fair hearing office issues a hearing decision adverse to the Member.
- 18) to be notified that when the resolution of an appeal or state fair hearing is adverse to the Member, that is the Contractor's adverse benefit determination is upheld, the Member is subject to cost recovery by the Contractor consistent with 42 CFR § 431.230(b), for those services furnished to the Member while the appeal and state fair hearing was pending.
- 6) 19) to receive interpretation services for their language.
- 7) 20) to have access to all medically necessary dental service provided in Federally Qualified Health Centers, Rural Health Clinics or Indian Health Care Providers Service Facilities, and access to emergency dental services outside the Contractor's network pursuant to federal law.
- 8) 21) to request a State Medi-Cal fair hearing, including information on the circumstances under which an expedited fair hearing is possible, after completion of the appeals process as in 5) above.
- 9) 22) to have access to, and where legally appropriate, receive copies of, amend or correct their dental record.
- 10) 23) to disenroll upon request. to be provided disenrollment requirements and limitations including information about procedures, timeframes, notices, grievances and State fair hearings related to, and reasons for which:
- a) the Contractor may request disenrollment
 - b) the Contractor is prohibited from requesting disenrollment, such as an adverse change in the Member's health status, or because of the Member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the plan seriously impairs the Contractor's ability to furnish services to either this particular Member or other Members).
 - c) the Member may request disenrollment, for cause, at any time.
 - i. causes for disenrollment include:
 - (a) the Member moves out of the Contractor's service area.
 - (b) the Member needs related services to be performed at the same time; not all related services are available within the

-
- provider network; and the Member's primary care provider or another provider determines that receiving the services separately would subject the Member to unnecessary risk.
- (c) other reasons, including poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the enrollee Member's care needs.
- ii. without cause, at the following times:
- (a) during the 90 days following the date of the beneficiary's initial enrollment into the plan, or during the 90 days following the date the State sends the beneficiary notice of that enrollment, whichever is later.
- (b) at least once every 12 months thereafter.
- (c) upon automatic reenrollment under paragraph (g) of this section, if the temporary loss of Medicaid eligibility has caused the beneficiary to miss the annual disenrollment opportunity.
- (d) when the State imposes the intermediate sanction specified in § 438.702(a)(4).
- 41) 24) to receive written Member informing materials in alternative formats (including Braille, large size print, and audio format) upon request and in a timely fashion appropriate for the format being requested.
- 42) 25) to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- 43) 26) to receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand.
- 44) 27) freedom to exercise these rights without adversely affecting how they are treated by the Contractor, providers, or the State.
- 45) 28) to have access to Contractor's health education programs and outreach services in order to improve dental health.
- 46) 29) to request a second opinion, including from a specialist at no cost.
- 30) to be free from the Contractor prohibiting, or otherwise restricting, a provider acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is his or her patient, for the following:
- a) the Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
- b) any information the Member needs to decide among all relevant treatment options.
- c) the risks, benefits, and consequences of treatment or non-treatment.
- 31) to be provided information about definitions of emergency care and how to access emergency dental treatment, and rules for coverage regardless of whether the provider that furnishes the services has a contract with the Contractor, under payment rules governed by Title XIX of the Act and the States.

- b. Contractor's written policy regarding Member responsibilities shall include providing accurate information to the professional staff, following instructions, and cooperating with the providers.

B. Member Services Staff

1. Contractor shall maintain the level of knowledgeable and trained staff sufficient to provide covered services to Members and all other services covered under this contract.
2. Contractor shall ensure Member services staff are trained on all contractually required Member service functions including, policies, procedures, and scope of benefits of this contract.
3. Contractor shall ensure that Member Services staff provides necessary support to Members with chronic conditions (such as asthma, diabetes, congestive heart failure) and disabilities, including assisting Members with complaint and grievance resolution, access barriers, and disability issues.
4. Contractor shall ensure that Member Services staff will refer potential Members to the DHCS enrollment broker when potential Members make a request for enrollment with Contractor.
5. Contractor shall conduct phone calls to Members who have not seen their Primary Care Dentist in the last 12 months. Contractor shall ensure that Members are set up with an appointment, if requested, and Members understand their rights to access to care and services. Contractor shall report the results to DHCS no later than thirty (30) calendar days following the end of the reporting month.
6. Contractor shall ensure that the average wait time during business hours for a Member to speak by telephone with Member services staff does not exceed ten minutes, in accordance with 28 CCR 1300.67.2.2(c)(10).

C. Call Center Reports

Contractor shall report biannually, no later than January 31st and July 31st of each calendar year, in a format outlined in Exhibit, A, Attachment 20, Deliverable Templates, the number of calls received by call type (questions, grievances, access to services, request for dental health education, etc.); the average speed to answer Member services telephone calls with a live voice; and the Member services telephone calls abandonment rate.

Contractor must maintain a weekly average "P" factor of no more than seven (7) percent. "P" factor is defined as the percentage of connected calls versus non-connected calls and/or busy signals.

D. Written Member Information

1. Contractor shall provide all new Members, and potential enrollees on request only, with written Member information as specified in 22 CCR 53926.5. Contractor is required to use State Developed Model Enrollee Handbook. Contractor shall develop and provide each Member, or family unit, a Member services guide that constitutes a fair disclosure of the provisions of the covered services including, but not limited to, dental health education. Contractor shall provide each enrollee an enrollee handbook, which serves as a summary of benefits and coverage, within a reasonable time after receiving notice of the beneficiary's enrollment.
2. Contractor shall distribute the Member information no later than seven (7) calendar days following enrollment. Contractor shall distribute Member information annually to each Member or family unit.
 1. Distribution of Member Information shall be considered provided after Contractor completes one of the following:
 - a. Mails a printed copy of the information to the enrollee's mailing address.
 - b. Provides the information by email after obtaining the enrollee's agreement to receive the information by email.
 - c. Posts the information on its website and advises the enrollee in paper or electronic form that the information is available on the Internet and includes the applicable Internet address provided that enrollees with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost.
 - d. Provides the information by any other method that can reasonably be expected to result in the enrollee receiving the information.
3. Contractor shall ensure that all written Member information is provided to Members at a sixth (6th) grade reading level. The written Member information shall ensure Members' understanding of the covered services, processes and ensure the Member's ability to make informed dental health decisions.

Written Member-informing materials shall be translated into the identified threshold and concentration languages discussed in Exhibit A, Attachment 11, Access and Availability, Provision H, Linguistic Services.

Written Member informing materials shall be provided in alternative formats (including Braille, large size print, and audio format) upon request and in a timely fashion appropriate for the format being requested.

Contractor shall establish policies and procedures to enable Members to make a standing request to receive all informing material in a specified alternative format.

4. In accordance with 42 CFR 438.10 (c)(6), if the Contractor chooses to provide the required information electronically to Members, it must be: in a format that is readily accessible; in a location on the Contractor's website that is prominent and readily accessible; and provided in an electronic form which can be electronically retained and printed. The information must be consistent with content and language requirements of 42 CFR 438.10 and Attachment 14. In addition, Contractor must notify Members that the information provided electronically is available in paper form without charge upon request, and Contractor must provide it to Members upon request within 5 business days.

54. The Member services guide shall be submitted to DHCS annually no later than thirty (30) calendar days after the beginning of each calendar year for review prior to distribution to Members. The Member services guide shall meet the requirements of an Evidence of Coverage and Disclosure Form (EOC/DF) as provided in 22 CCR 53920.5, 28 CCR 1300.51(d) and its Exhibit T (EOC) or U (Combined EOC/DF). In addition, the Member services guide shall meet the requirements contained in Health and Safety Code Section 1363, and; (a), as to print size, readability, and understandability of text, and shall include the following information:

- a. The plan name, address, telephone number and service area covered by the dental health plan.
- b. A description of the full scope of Medi-Cal Dental Managed Care covered benefits and all available services including dental health education as prescribed in Exhibit A, Attachment 12, Scope of Services, Provision D, Services for All Members, interpretive services provided by plan personnel and at service sites, and "carve out" services and an explanation of any service limitations and exclusions from coverage, or charges for services. Include information and identify services to which the Contractor or subcontractor has a moral objection to perform or support. Describe the arrangements for access to those services.
- c. Procedures for accessing covered services including that covered services shall be obtained through the plan's providers unless otherwise allowed under this contract.

Include a description of the Member identification card issued by the Contractor, if applicable, and an explanation as to its use in authorizing or assisting Members to obtain services.

- d. Compliance with the following may be met through distribution of a provider directory:

The address and telephone number of each service location (e.g., locations of hospitals, Primary Care Dentists (PCD), Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC) and Indian Health Service Facilities Care Providers (IHCP)).

The hours and days when each of these facilities is open, the services and benefits available to include but not limited to: the telephone number to call after normal business hours, the languages spoken, whether the office will see children 0-3, pregnant women and children with special health care needs.

Further, Contractor must make available in paper form upon request and electronic form, the following information about its network providers:

- 1) The provider's name as well as any group affiliation.**
- 2) Street address (es).**
- 3) Telephone number(s).**
- 4) Web site URL, as appropriate.**
- 5) Specialty, as appropriate.**
- 6) Whether the provider will accept new Members.**
- 7) The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training.**
- 8) Whether the provider's office/ facility has accommodations for people with physical disabilities, including offices, exam room(s) and equipment.**

The provider directory must include the information in the paragraph above for each of the provider types covered under the contract.

Information included in a paper provider directory must be updated at least monthly and electronic provider directories must be updated no later than 30 calendar days after the Contractor receives updated provider information.

Provider directories must be made available on the Contractor's Web site in a machine readable file and format as specified by federal regulation.

- e. Procedures for selecting or requesting a change in PCD at any time; any requirements that a Member would have to change PCD; reasons for which a request for a specific PCD may be denied; and reasons why a provider may request a change.
- f. The purpose and value of scheduling an initial dental health assessment appointment.
- g. The appropriate use of dental care services in a managed care system.
- h. The availability and procedures for obtaining after hours services (24-hour basis) and care, including the appropriate provider locations and telephone numbers. This shall include an explanation of the Members' right to interpretive services, at no cost, to assist in receiving after-hours services.
- i. Procedures for obtaining emergency dental care from specified plan providers or from non-plan providers, including outside Contractor's service area.

-
- j. Process for referral to specialists in sufficient detail so Member can understand how the process works, including timeframes.
 - k. Procedures for obtaining any transportation services to service locations that are offered by Contractor or available through the Medi-Cal program, and how to obtain such services. Include a description of both medical and non-medical transportation services and the conditions under which non-medical transportation is available.
 - l. Procedures for requesting an appeal or filing a grievance with Contractor, either verbally or in writing, including procedures for appealing decisions regarding Member's coverage or benefits, or filing grievances about a relationship to the organization or other dissatisfaction with the Contractor and/or providers. Include the title, address, and telephone number of the person responsible for processing and resolving appeals and grievances and responsible for providing assistance with completing the request. Information regarding the process shall include the requirements and the timelines for the Contractor to acknowledge receipt of and grievances, to resolve appeals and grievances, and to notify the Member of the resolution of grievances or appeals. Information shall be provided informing the Member that services previously authorized by the Contractor will continue while the appeal or grievance is being resolved.**
 - m. The causes for which a Member shall lose entitlement to receive services under this Contract as stipulated in Exhibit A, Attachment 16, Enrollments and Disenrollments, Provision D, Disenrollment.
 - n. Procedures for disenrollment, including an explanation of the Member's right to disenroll without cause at any time, subject to any restricted disenrollment period.
 - ~~o. Information on the Member's right to the Medi-Cal fair hearing process including information on the circumstances under which an expedited fair hearing is possible and information regarding assistance in completing the request, regardless of whether or not a grievance has been submitted or if the grievance has been resolved when a dental care service requested by the Member or provider has been denied, deferred or modified.~~ **submit a request for an appeal following an adverse benefit determination or to file a grievance for issues other than adverse benefit determinations, including timelines and information about how a Member may request a State fair hearing after exhausting the appeals process and receiving notice that the Contractor is upholding an adverse benefit determination.** Information on State Fair Hearing shall also include information on the timelines which govern a Member's right to a State Fair Hearing, pursuant to Welfare and Institutions Code Section 10951 and the State Department of Social Services' Public Inquiry and Response Unit toll-free telephone number (1-800-952-5253) to request a State hearing.
 - p. Information on the availability of, and procedures for obtaining, services at Federally Qualified Health Centers, Rural Health Clinics and Indian Health **Care Providers** ~~Service Facilities~~.

-
- q. Information furnished on the availability of transitional Medi-Cal eligibility and how the Member may apply for this program.
 - r. Information on how to access State resources for investigation and resolution of Member complaints, including a description of the DHCS Medi-Cal Managed Care Ombudsman Program and toll-free telephone number (1-888-452-8609), and the Department of Managed Health Care, Health Maintenance Organization (HMO) Consumer Service toll-free telephone number (1-888-466-2219).
 - s. Information concerning the provision and availability of services covered under the California Children's Services program from providers outside Contractor's provider network and how to access these services.
 - t. An explanation of the expedited disenrollment process for Members qualifying under conditions specified under 22 CCR Section 53889(j) which includes children receiving services under the Foster Care or Adoption Assistance Programs; Members with special health care needs; and Members already enrolled in another Medi-Cal, Medicare or commercial managed care plan.
 - u. An explanation of an American Indian Member's right not to be restricted in their access to **Indian Health Care Providers (IHCP)** ~~Indian Health Service facilities~~ by Contractor, and to disenroll from Contractor's plan at any time, without cause.
 - v. Any other information determined by DHCS to be essential for the proper receipt of covered services.

6. Member Identification Card

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

7. Annual Member Reminder

During the Member's enrollment anniversary month, the Contractor shall provide a maximum one page information guide to each Member annually. The guide shall include the Member's PCD's name, address, phone number, and operating hours as well as the Member Service's phone number. The guide should also include, but not be limited to information regarding benefits, PCD changes, and problems accessing services. Contractor shall submit for review and approval a sample of the guide to DHCS no later than thirty (30) calendar days after the beginning of each calendar year.

E. Member Notification of Changes in Access to Covered Services

1. Contractor shall ensure Members are notified in writing of any changes in the availability or location of covered services, or any other changes to the Enrollee Handbook or information listed in 42 CFR 438.10(f)(4) that DHCS defines as significant, at least thirty (30) calendar days prior to the effective date of such changes. In the event of a ~~natural disaster or~~ emergency or other unforeseeable circumstances, Contractor shall provide notice of the emergency or other unforeseeable circumstance to DHCS ~~to Members~~ as soon as possible, but no later than fourteen (14) calendar days. The notification to Members must be presented to and approved in writing by DHCS prior to its release.
2. Pursuant to 42 CFR 438.10(f)(1), Contractor must make a good faith effort to give written notice of termination of a contracted provider, within 15 calendar days after receipt or issuance of the termination notice, to each Member who received his or her primary dental care from, or was seen on a regular basis by, the terminated provider.
3. a. Contractor is subject to the information requirements of paragraph (b) of this section, a Contractor that would otherwise be required to provide, reimburse for, or provide coverage of, a counseling or referral service because of the requirement in 42 CFR 438.102 (a)(1) is not required to do so if the Contractor objects to the service on moral or religious grounds.

b. Information requirements: The Contractor's responsibility. A Contractor that elects the option provided in paragraph (a) of this section must furnish information about the services it does not cover as follows:
 - 1) To DHCS—
 - a) With its application for a Medi-Cal contract.
 - b) Whenever it adopts the policy during the term of the contract.
 - 2) Consistent with the provisions of § 438.10, to Members, within 90 days after adopting the policy for any particular service.
 - a) Although this timeframe would be sufficient to entitle the Contractor to the option provided in paragraph (a) of this section, the overriding rule in § 438.10(g)(4) requires the State, its contracted representative, to furnish the information at least 30 days before the effective date of the policy.
3. Contractor shall not be required to provide, reimburse for, or provide coverage of, a counseling or referral service that would otherwise be required under 42 CFR 438.102(a)(1) if Contractor objects to the service on moral or religious grounds. If Contractor elects to exercise this option, the following requirements must be met:
 - a. Contractor must furnish information about the services it does not cover to DHCS with its application for a Medi-Cal contract and whenever it adopts the policy during the term of the contract.

b. Contractor must furnish information about the service it does not cover to Members at least 30 days before the effective date of the policy consistent with 42 CFR 438.10(g)(4).

F. Primary Care Dentist Selection

1. Contractor shall implement and maintain DHCS approved procedures to ensure that each new Member has an appropriate and available PCD. Contractor shall ensure that Members are allowed to change a PCD, upon request, by selecting a different Primary Care Dentist from Contractor's network of providers.
2. Contractor shall permit any Indian Member, if eligible to receive services from an IHCP primary care dentist, to choose that ICHP as his or her primary care dentist as long as that provider has capacity to provide the services.
3. Contractor shall disclose to affected Members any reasons that their selection or change in PCD could not be made.
4. Contractor shall ensure that Members with an established relationship with a provider in Contractor's network, who have expressed a desire to continue their patient/provider relationship, are assigned to that provider without disruption in their care.

G. Primary Care Dentist Assignment

1. If the Member does not select a Primary Care Dentist within thirty (30) calendar days of the effective date of enrollment, Contractor shall assign that Member to a Primary Care Dentist and notify the Member and the assigned Primary Care Dentist no later than forty (40) calendar days after the Member's enrollment. When assigning a Primary Care Dentist to a Member, the Contractor must take into consideration the age, location and linguistics of the Member and provider. The Contractor shall ensure that adverse selection does not occur during the assignment process of Members to Primary Care dentists. If, at any time, a Member notifies the Contractor of a primary care dentist or subcontracting dental plan choice, such choice shall override the Member assignment to a Primary Care Dentist or subcontracting dental plan.
2. Contractor shall notify the Primary Care Dentist that a Member has selected or been assigned to the provider within ten (10) calendar days from when selection or assignment is completed by the Member or the Contractor, respectively. The Contractor shall provide to the PCD the address, phone number and all contact information the plan has on the Member.

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

1. Contractor shall notify Members of a decision to deny, defer, or modify requests for prior authorization by providing written notification to Members and/or their authorized representative, regarding any denial, deferral or modification of a request for approval to provide a dental care service. This notification must be provided as

specified in 22 CCR Sections 51014.1, 51014.2, 53894, and Health and Safety Code Section 1367.01.

2. Contractor shall provide for a written notification to the Member and the Member's authorized representative on a standardized form, approved by DHCS, informing the Member of all the following:
 - a. The Member's right to, method of obtaining, and time limit for requesting a State Fair Hearing **after exhausting the appeal process**, to contest the denial, deferral, or modification action and the decision the Contractor has made, the reason(s) for the action and the specific regulation(s) or plan authorization procedures supporting the action.
 - b. The Member's right to represent himself/herself at the fair hearing or to be represented by legal counsel, friend or other spokesperson.
 - c. The name and address of Contractor and the Department of Social Services (DSS) toll-free telephone number for obtaining information on legal service organizations for representation.
3. Contractor shall provide required notification to Members and their authorized representatives in accordance with the time frames set forth in 22 CCR 51014.1 and 53894. Such notice shall be deposited with the United States Postal Service in time for pick-up no later than the ~~third (3rd)~~ **second** business day after the decision is made, not to exceed fourteen (14) calendar days from receipt of the original request. If the decision is deferred because an extension is requested or justified as explained in Exhibit A, Attachment 7, Utilization Management, Provision C, Timeframes for Dental Authorization, Contractor shall notify the Member in writing of the deferral of the decision no later than fourteen (14) calendar days from the receipt of the original request. If the final decision is to deny or modify the request, Contractor shall provide written notification of the decision to Members no later than twenty-eight (28) calendar days from the receipt of the original request.

If the decision regarding a prior authorization request is not made within the time frames indicated in Exhibit A, Attachment 7, Utilization Management, Provision C, Timeframes for Dental Authorization, the decision is considered denied and notice of the denial must be sent to the Member on the date the time frame expires.

4. **The Contractor must mail the notice of adverse benefit determination at least 10 days prior to the date of action, when the action is a termination, suspension, or reduction of previously authorized Medi-Cal covered services.**

5. The Contractor must mail the notice of adverse benefit determination by the date of the action when any of the following occur:
 - a. The Member has died.
 - b. The Member submits a signed written statement requesting service termination.
 - c. The Member submits a signed written statement including information that requires service termination or reduction and indicates that he or she understands that service termination or reduction will result.
 - d. The Member has been admitted to an institution where he or she is ineligible under the plan for further services.
 - e. The Member's address is determined unknown based on returned mail with no forwarding address.
 - f. The Member is accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth.
 - g. A change in the level or medical care is prescribed by the Member's physician.
 - h. The notice involves an adverse determination with regard to preadmission screening requirements of section 1919(e)(7) of the Social Security Act of 1935.
 - i. The transfer or discharge from a facility will occur in an expedited fashion.
6. The Contractor may shorten the period of advance notice and mail the notice of adverse benefit determination five days prior to the date of action if:
 - a. The Contractor has facts indicating that action should be taken because of probable fraud by the Member; and
 - b. The facts have been verified, if possible, through secondary sources.
7. The Contractor must give notice of adverse benefit determination on the date of determination when the action is a denial of payment.

**EXHIBIT A, ATTACHMENT 15
MEMBER GRIEVANCE AND APPEAL SYSTEM**

A. Member Grievance and Appeal System

Contractor shall ~~implement and maintain~~ have in place a Member Grievance and Appeal system in accordance with Title 28 CCR Sections 1300.68 and 1368.01, Title 22 CCR Section 53858, 42 CFR Sections 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.416, and 438.424, and APL 17-003 and any future All Plan Letters related to compliance with the Member Grievance and Appeal System. (except Subdivision 1300.68(g).), and 1300.68.01, 22 CCR 53858, Exhibit A, Attachment 14, Member Services, Provision D, Written Member Information, Subprovision 4, Paragraph I). ~~Contractor shall resolve each grievance and provide notice to the Member as quickly as the Member's dental condition requires, or no later than thirty (30) calendar days from the date Contractor receives the grievance. Contractor shall notify the Member of the grievance resolution in a written Member notice.~~

1. Member Grievances

A Member may file a Grievance with the Contractor at any time. Contractor shall provide written acknowledgement to the affected Member within five (5) calendar days of receipt of the Grievance. Contractor shall resolve the Grievance and provide notice to the affected Member no later than 30 calendar days from the day Contractor receives the Grievance. Contractor shall notify the affected Member that there is no right to request a State Fair Hearing following Contractor's resolution of the Grievance. Contractor shall accept a Member Grievance either orally or in writing.

2. Standard Member Appeals of an Adverse Benefit Determination

- a. A Member, or their Provider on behalf of the Member, may request an Appeal of an Adverse Benefit Determination either orally or in writing. The parties to the Appeal included the Member and his or her representative or the legal representative of a deceased Member's estate. The date of an oral Appeal establishes the filing date for the Appeal.**
- b. A Member can request an Appeal of an Adverse Benefit Determination within 60 calendar days from receipt of the Notice of Adverse Benefit Determination. A Member must have exhausted the Contractor's internal Appeal process prior to proceeding to a State Fair Hearing. Contractor shall have only one level of Appeal for Members.**

 - 1) Contractor shall notify a Member who makes an oral request for an Appeal of an Adverse Benefit Determination that the Member's oral request for an Appeal shall be followed by a**

-
- written, signed Appeal unless the Member requests an expedited resolution of an Adverse Benefit Determination.
- 2)** Contractor shall assist the Member in preparing a written Appeal including notifying the Member of the location of Contractor's Appeal of an Adverse Benefit Form on Contract's website or providing the form to the Member upon request. Contractor shall also advise and assist the Member in requesting continuation of the disputed benefit(s) during an Appeal of the Adverse Benefit Determination.
- c.** Contractor shall provide written acknowledgement to the affected Member within five (5) calendar days of receipt of the Appeal. Contractor shall ensure an Appeal of an Adverse Benefit Determination is resolved and provide notice to the affected Member in a format approved by DHCS as expeditiously as the Member's health condition requires, but no later than 30 calendar days from the day Contractor receives the Appeal. In the event Contractor fails to resolve a standard Appeal within 30 calendar days from receipt, it shall provide notice to the Member, upon request, that the Member is deemed to have exhausted Contractor's internal Appeal process and has the right to proceed to a State Fair Hearing.
- d.** If Contractor or a State Fair Hearing officer reverses an Adverse Benefit Determination and the requested services were not furnished while the Appeal was pending, Contractor must authorize or provide the disputed services as expeditiously as the Member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. **If the Member received the disputed service while the Appeal was pending, the Contractor shall pay for those services in accordance with State policy and regulations.**
- e.** If the resolution of the Appeal or State Fair Hearing **is adverse to the Member, that is,** upholds the Contractor's Adverse Benefit Determination, the Contractor may, consistent with the state's policy on recoveries, under 42 CFR § 431.230(b), and as specified in this contract, recover the cost of services furnished to the Member while the Appeal and State Fair Hearing was pending, to the extent that services were furnished solely because of the requirements of this section.
- 3.** Expedited Appeals **of an Adverse Benefit Determination**
- a.** For Expedited Appeals of an Adverse Benefit Determination, Contractor shall comply with all requirements in 42 CFR § 438.410.

Contractor shall resolve an Expedited Appeal of an Adverse Benefit Determination and provide notice to the Member in a timeframe that is no longer than 72 hours after Contractor receives the Expedited Appeal unless there are grounds to extend the timeframe under Section 4 of this Provision.

- b. If a Contractor denies a request for an expedited resolution of an Appeal, it must transfer the Appeal to the standard timeframe for resolution of no longer than 30 calendar days from the day the Contractor receives the Appeal.
- c. If Contractor or a State Fair Hearing officer reverses an Adverse Benefit Determination and the requested services were not furnished while the Appeal was pending, the Contractor must authorize or provide the disputed services as expeditiously as the Member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. If the Member received the disputed service while the Appeal was pending, the Contractor shall pay for those services in accordance with State policy and regulations.
- d. Contractor must establish and maintain an expedited review process for appeals, when the Contractor determines (for a request from the Member) or when the provider indicates (in making the request on the Member's behalf or supporting the Member's request) that taking the time for a standard resolution could seriously jeopardize the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

4. Extension of Timeframes

- a. Contractor may extend the resolution timeframes for standard and expedited Appeals by up to 14 calendar days if:

 - 1) The Member requests the extension; or
 - 2) Contractor demonstrates to the satisfaction of the Department upon request, that there is a need for additional information and how the delay is in the Member's best interest.

b. **In the event that the Contractor extends timeframe without the Member's request is extended, Contractor shall:**

- 1) Make reasonable efforts to provide the Member with prompt oral notice of the delay.**
- 2) Provide the Member written notice, within 2 calendar days, of the reason for the decision to extend the timeframe and inform the Member of the right to file a Grievance if he or she disagrees with that decision.**
- 3) Resolve the Appeal as expeditiously as the Member's health requires and in no event can Contractor's resolution extend resolution beyond the initial 14 calendar day extension.**

d) In the event the Contractor reverses a decision to deny, defer or limit services, the Contractor shall provide the disputed service(s) as expeditiously as possible if a continuation of benefits was not requested.

5. Notice of Adverse Benefit Determination

a. A Notice of Adverse Benefit Determination is a formal letter, in a format provided or approved by DHCS, informing a Member of any of the following actions taken by the Contractor:

- 1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit.**
- 2) The reduction, suspension, or termination of a previously authorized service.**
- 3) The denial, in whole or in part, of payment for a service.**
- 4) The failure to provide services in a timely manner.**
- 5) The failure to act within the required timeframes for standard resolution of Grievances and Appeals.**
- 6) The denial of a Member's request to dispute financial liability.**

- b. A written Notice of Adverse Benefit Determination shall be in a format and language, that, at a minimum, meets the standards set forth in 42 CFR 438.10 and must include all of the following:**
- 1) The action that the Contractor or its subcontractor has taken or intends to take;**
 - 2) The reason for the action, including notification to the Member of the right to request, free of charge, all documents and records, and other relevant information. Such information includes medical necessity criteria, and any process, strategies, or evidentiary standards used in setting coverage limits;**
 - 3) The requirement that the Member or Provider request an internal Appeal with Contractor no later than 60 calendar days from the date on the Notice of Adverse Benefit Determination before the Member can request a State Fair Hearing;**
 - 4) The Member's right to request a State Fair Hearing and how to request a State Fair Hearing if Contractor fails to send a resolution notice in response to the Appeal of the Notice of Adverse Benefit Determination within 30 calendar days;**
 - 5) Procedures for exercising the Member's rights specified in this section;**
 - 6) Circumstances under which an expedited review is available and how to request it;**
 - 7) The Member's right to have benefits continue pending the resolution of the Appeal; and**
 - 8) How to request a continuation of benefits.**

6. Requirements for Notice of Appeal Resolution of Appeal of an Adverse Benefit Determination

Contractor shall provide written notice of the resolution of the Member's Appeal of an Adverse Benefit Determination in a format provided or approved by DHCS. Written notice must include the following:

- a. The results of the resolution and the date it was completed.**
- b. For Appeals not resolved wholly in favor of the Member Contractor's written notice to the Member shall include the following information:**
 - 1) The right to request a State Fair Hearing, that a State Fair Hearing must be requested 120 calendar days from Contractor's notice of resolution and how to request a State Fair Hearing;**
 - 2) The right to request and to receive continuation of benefits while the hearing is pending and how to request continuation of benefits, including the timeframe in which the request shall be made; and**
 - 3) The right to request a review of Contractor's resolution by the California Department of Managed Health Care, including but not limited to an Independent Medical Review, if appropriate.**

B. Grievance and Appeal System Oversight

Contractor shall implement and maintain procedures as pursuant to **28 CCR 1300.68, 1300.68.01 and Title 22 CCR 53858** to monitor Contractor's Member Grievance **and Appeal** system and the expedited review of grievances **and appeals**, which shall include, but **are** not limited to:

- 1. Procedure to ensure timely **acknowledgement**, resolution and feedback to complainant. **Provide verbal notice of the resolution of an expedited review. In the case of a grievance, Contractor shall provide a written resolution of a grievance within 30 calendar days of receipt. In the case of an Appeal of an Adverse Benefit Determination, Contractor shall provide a written resolution of the Appeal within 30 calendar days of receipt of the Appeal. In the case of an Expedited Appeal, Contractor shall provide oral notification of the resolution of the Expedited Appeal within 72 hours of receipt.**

-
2. Procedure to ensure the Member is provided with any reasonable assistance in completing Grievance and Appeal forms and other procedural steps related to a Grievance or Appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers with Teletypewriter Telephone/Telecommunication Devices for the Deaf (TTY/TDD) and interpreter capability.
 3. Procedure for systematic aggregation and analysis of the Grievance or Appeal data and use for quality improvement.
 4. Procedure to ensure that the ~~every~~ every Grievance and Appeal submitted is reported to an appropriate level, i.e., dental issues versus dental care delivery issues. To this end, Contractor shall ensure that any grievance involving the Appeal of a denial based on lack of medical necessity, Appeal of a denial of a request for expedited resolution of a Grievance, or an Appeal that involves clinical issues shall be resolved by a dental care professional with appropriate clinical expertise in treating the Member's condition or disease.
 5. Procedure to ensure the participation of individuals with authority to require corrective action. Grievances related to medical/dental quality of care issues shall be referred to the Contractor's Dental Director.
 6. ~~Procedure to ensure that the person making the final decision for the proposed resolution of a grievance or appeal has not participated in any prior decisions related to the grievance or appeal.~~ Procedure to ensure that requirements of Title 22 CCR Section 51014.2 are met regarding services to Members during the Grievance and Appeal process.
 7. Procedure to ensure that the person making the final decision for the proposed resolution of a Grievance or Appeal has not participated in any prior decisions related to the Grievance or Appeal and is not a subordinate of any individual who was involved in a previous level of review or decision-making.
 8. Procedure to ensure that decision makers on Grievances and Appeals of adverse benefit determinations take into account all comments, documents, records, and other information submitted by the Member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.
 9. Procedures to ensure that Members are given a reasonable opportunity ~~to present~~, in person and in writing, ~~or in person before the individual(s) resolving the grievance or appeal,~~ to present evidence and testimony and make legal and factual arguments ~~and law~~ in support of their Grievance or Appeal. In the case of expedited Appeal resolution, Contractor must inform Members of

the limited time available for this sufficiently in advance of the resolution timeframe.

10. Procedure to ensure Contractor complies with 42 CFR 438.406(b)(5) and provides the Member and his or her representative the Member's case file, including medical records, other documents and records, and any new additional evidence considered, relied upon, or generated in connection with the Appeal of the adverse benefit determination. The case file must be provided free of charge and sufficiently in advance of the resolution timeframe for standard Appeals (30 calendar days) and expedited Appeals (72 hours) resolutions.
11. Procedure to provide specified information about the Grievance and Appeal system to all providers and subcontractors at the time they enter into a contract.

C. Grievance and Appeal Log and Quarterly Grievance and Appeal Report

1. Contractor shall maintain, and have available for DHCS review, Grievance and Appeal logs, including copies of Grievance and Appeal logs of any sub-contracting entity delegated the responsibility to maintain and resolve Grievances and Appeals. Grievance and Appeal logs shall include all the required information set forth in 22 CCR 53858(e), Title 28 CCR 1300.68(b)(5), 42 CCR 438.416(b) and (c), and APL 17-003 and any future All Plan Letters.
2. Contractor shall submit quarterly Grievance and Appeal reports in the required DMHC format no later than thirty (30) calendar days following the end of the reporting quarter, to include, but not be limited to, the required elements set forth in 28 CCR 1300.68(f). The Grievance and Appeal report should include an explanation for each Grievance or Appeal that was not resolved within thirty (30) calendar days of receipt of the Grievance or Appeal.
 - a. In addition to the types or nature of Grievances and Appeals listed in 28 CCR 1300.68(f)(2)(D), the report shall also include, but not be limited to, untimely assignments to a Primary Care Dentist, issues related to cultural sensitivity and linguistic access, and difficulty with accessing specialists.
 - b. In addition to the reporting requirements above, Contractor shall provide the following in the Medi-Cal Category of the report:
 - 1) The total number of Grievances and Appeals received.
 - 2) The average time it took to resolve Grievances and Appeals, which includes providing written notification to the Member.

- 3) A listing of the zip codes, ethnicity, gender, and primary language of Members who filed Grievances **or Appeals**.
3. Contractor shall submit reports resulting from its quarterly review and analysis of all recorded Grievances **and Appeals** as required by 22 CCR 53858(e)(4) in the required DMHC format. Upon request Contractor shall submit the additional information on a Grievance **or Appeal** to DHCS within five (5) calendar days.

D. Parties to State Hearing

The parties to the State hearing shall include the Contractor as well as the Member and his or her representative or the **legal** representative of a deceased **enrollee Member**'s estate.

E. Recordkeeping Requirements

- 1. The Contractor **and subcontractors** shall maintain records of grievances and appeals and must review the information as part of its ongoing monitoring procedures, as well as any updates and revisions to the State quality strategy.**
- 2. The record of each Grievance or Appeal shall contain, at a minimum, all of the following information:**
 - a. A general description of the reason for the Appeal or Grievance.**
 - b. The date the Appeal or Grievance was received.**
 - c. The date of each review or, if applicable, review meeting.**
 - d. Resolution at each level of the Appeal or Grievance, if applicable.**
 - e. Date of resolution at each level, if applicable.**
 - f. Name of the covered person for whom the Appeal or Grievance was filed.**
 - g. The record shall be accurately maintained in a manner accessible to the state and available upon request to CMS.**

F. Continuation of Benefits

1. Contractor shall continue the Member's benefits throughout all pending Contractor Appeals and State Fair Hearings if all of the following occur:
 - a. The Member files the request ~~for an appeal within 60 calendar days following the date on the adverse benefit determination notice; for an appeal timely;~~
 - b. The appeal involves the termination, suspension, or reduction of a previously authorized service;
 - c. The ~~Member's~~ services were ordered by an authorized provider;
 - d. The period covered by the original authorization has not expired; and
 - e. The Member timely files for continuation of benefits. "Timely files" means the Member files for continuation of benefits on or before the following, whichever is later:
 - 1) Within ten (10) calendar days of the Contractor sending the notice of adverse benefit determination.
 - 2) The intended effective date of the Contractor proposed adverse benefit determination.
2. If, at the Member's request, the Contractor shall continue or reinstate the Member's benefits while the Appeal or State Fair Hearing is pending, the benefits shall continue until one of following occurs:
 - a. The Member withdraws the Appeal or request for State Fair Hearing.
 - b. The Member fails to request a state fair hearing and continuation of benefits within ten (10) calendar days after the Contractor sends the notice of an adverse resolution to the Member's appeal.
 - c. A State Fair Hearing office issues a hearing decision adverse to the Member.
3. If the final resolution of the Appeal or State Fair Hearing is adverse to the Member, that is, upholds Contractor's adverse benefit determination, the Contractor may recover the cost of services furnished to the Member while the Appeal and State Fair Hearing was pending, to the extent that they were furnished solely because of the requirements of this section.

**EXHIBIT A, ATTACHMENT 16
ENROLLMENTS AND DISENROLLMENTS**

A. Enrollment Program

Contractor shall cooperate with the DHCS enrollment program and shall provide to DHCS' Enrollment Contractor a list of network providers (provider directory), linguistic capabilities of the providers and other information deemed necessary by DHCS to assist Members, and potential enrollees, in making an informed choice in dental plans. Contractor shall submit a copy of the provider directory to DHCS upon request. DHCS reserves the right to halt new enrollment into a plan if the Contractor fails to achieve the benchmarks for the performance measures and/or at the discretion of the Department.

B. Enrollment

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

1. Enrollment – General

Eligible beneficiaries residing within the service area of Contractor may be enrolled at any time during the term of this contract. Eligible beneficiaries shall be accepted by Contractor in the order in which they apply without regard to race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, need for dental services, or disability.

2. Coverage

Member coverage shall begin at 12:01 a.m. on the first day of the calendar month for which the eligible beneficiary's name is added to the approved list of Members furnished by DHCS to Contractor.

Contractor shall provide covered services to a child born to a Member for the month of birth and the following month. For a child born in the month immediately preceding the mother's membership, Contractor shall provide covered services to the child during the mother's first month of enrollment. No additional capitation payment will be made to the Contractor by DHCS.

3. Exception to Enrollment

An eligible beneficiary in a mandatory aid code category is not required to enroll when a request for an exemption under 22 CCR 53923.5 has been approved.

4. Enrollment Restriction

Enrollment will proceed unless restricted by DHCS. Such restrictions will be defined in writing and the Contractor notified at least ten (10) calendar days prior to the start of the period of restriction. Release of restrictions will be in writing and transmitted to the Contractor at least ten (10) calendar days prior to the date of the release.

5. Enrollment Capacity

All eligible beneficiaries shall be accepted by Contractor up to the limits of Contractor's enrollment capacity approved by DHCS.

6. Reenrollment

DHCS will automatically reenroll an eligible beneficiary who was disenrolled because he/she lost Medicaid eligibility for a period of 2 months or less.

7. Enrollment Discrimination Prohibited.

The Contractor, PIHPs, PAHPs, PCCMs and PCCM entities shall provide as follows:

- a. Accept individuals eligible for enrollment in the order in which they apply without restriction (unless authorized by CMS), up to the limits set under the contract.**
- b. Enrollment is voluntary, except in the case of mandatory enrollment programs that meet the conditions set forth in 42 § 438.50(a).**
- c. The Contractor, PIHP, PAHP, PCCM or PCCM entity shall not, on the basis of health status or need for health care services, discriminate against individuals eligible to enroll.**
- d. The Contractor, PIHP, PAHP, PCCM or PCCM entity shall not discriminate against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability and shall not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin, sex, sexual orientation gender identity, or disability pursuant to 42 CFR § 438.3(d).**

C. Continuance of Membership

A Member's enrollment shall continue unless this contract is terminated, or the Member is disenrolled under the conditions described in Provision D, Disenrollment. Upon

expiration of this contract, Contractor shall retain its enrolled Members if prior to expiration of the contract, Contractor renews its participation in the Medi-Cal Dental Managed Care Program, and without a break in service, receives a new contract. Notwithstanding this Provision C, each Member maintains the right to change dental plans at any time.

D. Disenrollment

The Enrollment Contractor shall process a Member disenrollment under the following conditions, ~~subject to approval by DHCS~~, in accordance with the provisions of 22 CCR 53925.5:

1. Disenrollment of a Member is mandatory when:
 - a. The Member requests disenrollment, subject to any lock-in restrictions on disenrollment under the federal lock-in option, if applicable.
 - b. The Member's eligibility for enrollment with Contractor is terminated or eligibility for Medi-Cal is ended, including the death of the Member.
 - c. Enrollment was in violation of 22 CCR 53400, 53921, 53921.5, 53922 or 53402, or requirements of this Contract regarding marketing, and DHCS or Member requests disenrollment.
 - d. Disenrollment is requested in accordance with Welfare and Institutions Code, Sections 14303.1 regarding merger with other organizations, or 14303.2 regarding reorganizations or mergers with a parent or subsidiary corporation.
 - e. There is a change of a Member's place of residence to outside Contractor's service area.
 - f. Disenrollment is based on the circumstances described in Exhibit A, Attachment 14, Member Services, Provision 4, Written Member Information, Subprovision 4, Paragraphs t or u.

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

2. Contractor may recommend to DHCS the disenrollment of any Member in the event of a breakdown in the "Contractor/Member relationship" which makes it impossible for Contractor's providers to render services adequately to a Member. Except in cases described in Paragraph b below, or fraud, Contractor shall make, and document, significant efforts to resolve the problem with the Member through avenues such as reassignment of Primary Care Dentist or education before requesting a Contractor-initiated disenrollment. In cases of Contractor-initiated disenrollment of a Member, Contractor must submit to DHCS a written request with

supporting documentation for disenrollment based on the breakdown of the "Contractor/Member relationship." Contractor-initiated disenrollment's must be prior approved by DHCS and shall be considered only under any of the following circumstances:

- a. Member is repeatedly verbally abusive to contracting Providers, ancillary or administrative staff, Subcontractor staff or to other plan Members.
- b. Member physically assaults a Contractor's staff person, contracting provider or staff person, or other Member, or threatens another individual with a weapon on Contractor's premises or subcontractor's premises. In this instance, Contractor or subcontractor shall file a police or security agency report and file charges against the Member.
- c. Member is disruptive to Contractor operations, in general.
- d. Member habitually uses providers not affiliated with Contractor for non-emergency services without required authorizations (causing Contractor to be subjected to repeated provider demands for payment for those services or other demonstrable degradation in Contractor's relations with community providers).
- e. Member has allowed the fraudulent use of Medi-Cal coverage under the plan, which includes allowing others to use the Member's plan identification card to receive services from Contractor.
- f. Contractor may not request disenrollment because of an adverse change in the ~~enrollee~~ **Member's** health status, or because of the ~~enrollee~~ **Member's** utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs in accordance with ~~242~~ CFR 438.56(b)(2).

3. Members may choose to disenroll from the plan if the plan does not cover the service the Member seeks because of moral or religious objections.

~~3.4.~~ A Member's failure to follow prescribed treatment (including failure to keep established dental appointments) shall not, in and of itself, be good cause for the approval by DHCS of a Contractor-initiated disenrollment request unless Contractor can demonstrate to DHCS that, as a result of the failure, Contractor is exposed to a substantially greater and unforeseeable risk than that otherwise contemplated under the Contract and rate-setting assumptions.

~~4.5.~~ The problem resolution attempted prior to a Contractor-initiated disenrollment described in Subprovision 2 above must be documented by Contractor. A formal procedure for Contractor-initiated disenrollments shall be established by Contractor and approved by DHCS. As part of the procedure, the Member shall be notified in

writing by Contractor of the intent to disenroll the Member for cause and allowed a period of no less than twenty (20) calendar days to respond to the proposed action.

- a. Contractor must submit a written request for disenrollment and the documentation supporting the request to DHCS for approval. The supporting documentation must establish the pattern of behavior and Contractor's efforts to resolve the problem. DHCS shall review the request and render a decision in writing within ten (10) business days of receipt of a Contractor request and necessary documentation. If the Contractor-initiated request for disenrollment is approved by DHCS, DHCS shall submit the disenrollment request to the Enrollment Contractor for processing. Contractor shall be notified by DHCS of the decision, and if the request is granted, shall be notified by the Enrollment Contractor of the effective date of the disenrollment. Contractor shall notify the Member of the disenrollment for cause if DHCS grants the Contractor-initiated request for disenrollment.
 - b. Contractor shall continue to provide covered services to the Member until the effective date of the disenrollment.
- 5- **6.** Enrollment shall cease no later than midnight on the last day of the first calendar month after the Member's disenrollment request and all required supporting documentation are received by DHCS. On the first day after enrollment ceases, Contractor is relieved of all obligations to provide covered services to the Member under the terms of this Contract. Contractor agrees in turn to return to DHCS any capitation payment forwarded to Contractor for persons no longer enrolled under this Contract.
- 6- **7. Regardless of the procedures followed, the effective date of an approved disenrollment must be no later than the first day of the second month following the month in which the Member requests disenrollment or the Contractor refers the request to DHCS. If the Contractor fails to make the determination within the timeframes specified in this section, the disenrollment is considered approved for the effective date that would have been established had DHCS or the Contractor complied within the timeframes specified.**
- 7- **8.** Contractor shall implement and maintain procedures to ensure that all Members requesting disenrollment or information regarding the disenrollment process are immediately referred to the Enrollment Contractor.
-

E. Record of Member Deaths

Contractor must submit a written report as necessary to DHCS listing deceased members to the extent Contractor has knowledge of a Member's death. The report shall be submitted immediately upon notification and shall include the Member's name, Member's Medi-Cal number, date of birth, and date of death. The absence of reports indicates Contractor does not have knowledge of any Member deaths.

**EXHIBIT A, ATTACHMENT 17
MARKETING****A. Training and Certification of Marketing Representatives**

If Contractor conducts marketing, Contractor shall develop a training and certification program for marketing representatives, as described in this Exhibit A, Attachment 17, and ensure that all staff performing marketing activities or distributing marketing material is appropriately certified.

1. Contractor is responsible for all marketing activity conducted on behalf of the Contractor. Contractor will be held liable for any and all violations by any marketing representatives. Marketing staff may not provide marketing services for more than one Contractor. Marketing representatives shall not engage in marketing practices that discriminate against an eligible beneficiary or potential enrollee because of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status or disability, or practices that reasonably may be interpreted as intended to influence an eligible beneficiary to not enroll in, or disenroll from another plan.

2. Training Program

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

- a. An explanation of the Medi-Cal Dental Program, including both Medi-Cal Dental FFS and capitated Contractors, and eligibility, **and the Beneficiary Support System.**
- b. Medi-Cal Dental Scope of Services.
- c. An explanation of the Contractor's administrative operations and dental health delivery system program, including the service area covered, excluded services, additional services, conditions of enrollment and aid categories.
- d. An explanation of Utilization Management (how the beneficiary is obligated to obtain all non-emergency dental care through the Contractor's provider network and describing all precedents to receipt of care like referrals, prior authorizations, etc.).
- e. An explanation of the Contractor's grievance procedures.
- f. An explanation of how a Member disenrolls from the Contractor and conditions for both voluntary and mandatory disenrollment reasons.

-
- g. An explanation of the requirements of confidentiality of any information obtained from Members including information regarding eligibility under any public welfare or social services program.
 - h. An explanation of how marketing representatives will be supervised and monitored to assure compliance with regulations.
 - i. An explanation of acceptable communication and sales techniques. This shall include an explanation of prohibited marketing representative activities and conduct.
 - j. An explanation of the consequences of misrepresentation and marketing abuses (i.e., discipline, suspension of marketing, termination, civil and criminal prosecution, etc.). The marketing representative must understand that any abuse of marketing requirements can also cause the termination of the Contractor's contract with the State.
 - k. An explanation that discrimination in enrollment and failure to enroll a Member due to a pre-existing dental condition are illegal.

B. DHCS Approval

1. Contractor shall not conduct marketing activities without written approval of its marketing plan, or changes to its marketing plan, from DHCS. In cases where the Contractor wishes to conduct an activity not included in the marketing plan, Contractor shall submit a request to include the activity and obtain written, prior approval from DHCS. Contractor must submit the written request within thirty (30) calendar days prior to the marketing event, unless DHCS agrees to a shorter period. The absence of any written notifications indicates the Contractor does not have any additional marketing activities the Contractor wishes to conduct.
2. Contractor shall notify DHCS at least thirty (30) calendar days in advance of Contractor's participation in all marketing events. In cases where Contractor learns of an event less than thirty (30) calendar days in advance, Contractor shall provide notification to DHCS immediately. Notifications received less than forty-eight (48) hours prior to the event will not be approved by DHCS.
3. All marketing materials, and changes in marketing materials, including but not limited to, all printed materials, illustrated materials, videotaped and media scripts, shall be approved in writing by DHCS prior to distribution.
4. Contractor's training and certification program and changes in the training and certification program shall be approved in writing by DHCS prior to implementation.

C. Marketing Plan

If Contractor conducts marketing, Contractor shall develop a marketing plan as specified below. The marketing plan shall be specific to the Medi-Cal Dental Managed Care Program only. Contractor shall ensure that the marketing plan, all procedures and materials, are accurate and do not mislead, confuse or defraud. **The contractor must distribute marketing materials to its entire service area under 42 CFR § 438.104(b)(1)(ii).**

1. Contractor shall submit a marketing plan to DHCS for review and approval on an annual basis no later than thirty (30) calendar days after the beginning of each calendar year. The marketing plan, whether new, revised, or updated, shall describe the Contractor's current marketing procedures, activities, and methods. No marketing activity shall occur until the marketing plan has been approved by DHCS.

a. The marketing plan shall have a table of contents section that divides the plan into chapters and sections. Each page shall be dated and numbered so chapters, sections, or pages, when revised, can be easily identified and replaced with revised submissions.

b. Contractor's marketing plan shall contain the following items and exhibits:

1) Mission Statement or Statement of Purpose for the marketing plan.

2) Organizational Chart and Narrative Description

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

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

3) Marketing Locations

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

4) Marketing Activities

All marketing methods and marketing activities Contractor expects to use, or participate in, shall be described. Contractor shall comply with the guidelines described, as applicable, in 22 CCR 53880 and 53881, Welfare and Institutions Code Sections 10850(b), 14407.1, 14408, 14409, 14410, and 14411, and as follows:

- a) Contractor shall not engage in door to door, cold call, telephone, or other marketing for the purpose of enrolling Members or potential enrollees.
- b) Contractor shall obtain DHCS approval to perform in-home marketing presentations and shall provide strict accountability, including documentation of the prospective Member's request for an in-home marketing presentation or a documented telephone log entry showing the request was made.
- c) Contractor shall not conduct marketing presentations at primary dental care sites.
- d) Include a letter or other document that verifies cooperation or agreement between the Contractor and an organization to undertake a marketing activity together and certify or otherwise demonstrate that permission for use of the marketing activity/event site has been granted.

5) Marketing Materials

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

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

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

6) Marketing Distribution Methods

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

7) Monitoring and Reporting Activities

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

8) Miscellaneous

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

-
- a) Contractor shall not seek to influence enrollment in conjunction with the sale or offering of any private insurance.
 - b) The conduct of activities or procedures not included in an approved marketing plan shall constitute a violation of Welfare and Institutions Code Section 14408 and be subject to sanctions in accordance with Section 14409.

**EXHIBIT A, ATTACHMENT 18
TARGETED LOW-INCOME CHILD MEMBER TRANSITION**

A. Continuity of Care

In addition to Exhibit A, Attachment 11, Access and Availability, Contractor also agrees to the following:

1. Contractor shall provide Targeted Low-Income Child Members who have transitioned to Medi-Cal continued access to their current Primary Care Dentist if the Primary Care Dentist is a contracted provider in the Contractor's Medi-Cal provider network. Contractor shall also provide continued access if the Primary Care Dentist is not within Contractor's Medi-Cal provider network, if the nonparticipating provider agrees in writing to be subject to the same contractual terms and conditions that are imposed upon currently contracting providers providing similar services and who are practicing in the same or a similar geographic area as the nonparticipating provider, including, but not limited to, payment for services, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements. If the nonparticipating provider does not agree to comply or fails to comply with these contractual terms and conditions, the plan is not required to recognize the provider as a plan provider.
2. Contractor shall provide for the completion of covered services for the treatment of certain specified conditions if: (a) the services were being provided by a provider that is within the Contractor's Medi-Cal provider network at the time of the transition, or (b) the covered services were being provided by a nonparticipating provider who agrees to comply with the plan's contractual terms and conditions, as described in A.1. Enrollees are entitled to continuation of services from such providers for the following circumstances and timeframes:
 - a) An acute condition (defined as a dental condition that involves a sudden onset of symptoms due to an illness, injury, or other dental problem that requires prompt dental attention and that has a limited duration).
 - b) A serious chronic condition. Completion of covered services under this paragraph shall not exceed 12 months from the transition date or 12 months from the effective date of coverage for a newly covered enrollee.
 - c) Performance of a surgery or other procedure that is authorized by the Plan as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the transition date or within 180 days of the effective date of coverage for a newly covered enrollee.
3. If a Targeted Low-Income Child Member who has transitioned into Medi-Cal is not able to remain with their Primary Care Dentist, the Contractor shall develop a care plan on how the Member will continue to receive services which they had been receiving at the time of the transition. Contractor shall report this care plan to DHCS

to show how continuity of care is being provided and the outcome of Contractor's care plan, in the manner and format specified by DHCS.

B. Required Reports for the Targeted Low-Income Child Member Transition to Medi-Cal

Contractor shall submit to DHCS the following reports:

1. In addition to the requirements set forth in Exhibit A, Attachment 8, Provider Network, Provision G, Changes to Provider Network Report, the Provider Network report shall include information on whether additions or deletions to the contracted provider list are from providers who had accepted Targeted Low-Income Child Members.
2. In addition to the requirements set forth in Exhibit A, Attachment 15, Provision C, Grievance Log and Quarterly Grievance Report, Contractor shall also include information on grievances related to access to care filed by Targeted Low-Income Child Members who transitioned into Medi-Cal, in the manner and format specified by DHCS.
3. Other information pertaining to transition implementation, enrollees, and providers, as requested by DHCS.

**EXHIBIT A, ATTACHMENT 19
DELIVERABLE SCHEDULE**

*The annual reports will be due thirty (30) calendar days after beginning of every calendar year. Quarter 1 will be January-March; Quarter 2 will be April-June; Quarter 3 will be July-September; and Quarter 4 will be October-December.

Deliverable	Provision	Frequency*	Submission Due Date
Key Personnel (Disclosure Form)	Exhibit A, Att. 2, Provision B	Annually	No later than thirty (30) calendar days after the beginning of every calendar year
Annual Certified Financial Statement (audited by a Certified Public Accountant)	Exhibit A, Att. 3, Provision B	Annually	No later than one- hundred and twenty (120) calendar days after the close of Contractor's Fiscal Year
Annual Financial Statements	Exhibit A, Att. 3, Provision B	Annually	No later than one- hundred and twenty (120) calendar days after the close of Contractor's Fiscal Year
Quarterly Financial Statements	Exhibit A, Att. 3, Provision B	Quarterly	No later than forty-five (45) calendar days after the close of Contractor's Fiscal Quarter
Monthly Financial Statements	Exhibit A, Att. 3, Provision C	Monthly, if required by DMHC	No later than thirty (30) calendar days after each reporting month
Medi-Cal Only Financial Statement	Exhibit A, Att. 3, Provision B, Subprovision 4 (annual) and Provision B, Subprovision 9 (quarterly)	Annually and Quarterly	No later than one- hundred and twenty (120) calendar days after the close of Contractor's Fiscal Year/no later than forty-five (45) calendar days after the close of Contractor's Fiscal Quarter
Encounter Data	Exhibit A, Att. 4, Provision B	Monthly	Will be notified through an All Plan Letter (APL)
Quality Improvement Committee Meeting Minutes	Exhibit A, Att. 5, Provision D	Quarterly	No later than thirty (30) calendar days after the end of the reporting quarter
Quality Improvement Annual Report	Exhibit A, Att. 5, Provision I	Annually	No later than thirty (30) calendar days after the beginning of every

			calendar year
External Quality Review Compliance Audit	Exhibit A, Att. 5, Provision J	Annually	No later than December 15 th of every calendar year
Provider Monitoring Report	Exhibit A, Att. 5, Provision K, Subprovision 4	Quarterly	No later than thirty (30) days after the end of the reporting quarter
Review of Utilization Data	Exhibit A, Att. 7, Provision D	Annually	No later than thirty (30) calendar days after the beginning of every calendar year
Self-Reported Monthly Utilization Data	Exhibit A, Att. 7, Provision D	Monthly	No later than thirty (30) calendar days after the end of the reporting month
Changes to Provider Network Report	Exhibit A, Att. 8, Provision G	Monthly	Within fifteen (15) calendar days following the end of the month
Plan Provider Network Report	Exhibit A, Att. 8, Provision H	Monthly	No later than fifteen (15) calendar days following the end of the reporting month
Timely Access Report	Exhibit A, Att. 11, Provision B, Subprovision 3	Quarterly	No later than thirty (30) calendar days after the end of the reporting quarter
Specialty Referral Report	Exhibit A, Att. 11, Provision B, Subprovision 5	Biannually	No later than January 31 st and July 31 st of every calendar year
Health Education Programs	Exhibit A, Att. 12, Provision D, Subprovision 1	Annually	No later than thirty (30) calendar days after the beginning of every calendar year
Member Phone Call Report	Exhibit A, Att. 14, Provision B	Monthly	No later than thirty (30) calendar days after the end of the reporting month
Call Center Reports	Exhibit A, Att. 14, Provision C	Biannually	No later than January 31 st and July 31 st of every calendar year
Member Services Guide (Evidence of Coverage)	Exhibit A, Att. 14, Provision D, Subprovision 4	Annually	No later than thirty (30) calendar days after the beginning of every calendar year
Member Reminder Template	Exhibit A, Att. 14, Provision D, Subprovision 6	Annually	No later than thirty (30) calendar days after the beginning of every

			calendar year
Grievance Report	Exhibit A, Att. 15, Provision C, Subprovision 2	Quarterly	No later than thirty (30) calendar days after the end of the reporting quarter
Marketing Plan	Exhibit A, Att. 17, Provision C. Subprovision 1.	Annually	No later than thirty (30) calendar days after the beginning of every calendar year

**EXHIBIT A, ATTACHMENT 20
DELIVERABLE TEMPLATES**

Contractor shall use the templates developed by DHCS in this attachment for submitting specific deliverables. DHCS reserves the right to modify any of the templates or create templates for other deliverables. DHCS will notify Contractor through an All Plan Letter in the event of a change to a template or addition of templates.

1. Medi-Cal Dental Only Financial Statement (Exhibit A, Attachment 3, Provision B, Subprovision 9)

QUARTERLY STATEMENT AS OF [date] - [Plan Name] MEDI-CAL DENTAL ONLY REVENUES & EXPENSES		
Member Months: (X)	1	2
	Current Period	Year-To-Date
REVENUES		
1. MEDI-CAL		
EXPENSES		
2. Dental		
Administration		
3. Compensation		
4. Interest Expense		
5. Occupancy, Depreciation and Amortization		
6. Management Fees		
7. Marketing		
8. Affiliate Ammonization Services		
9. Aggregate Write-Ins for other Administration		
10. Quality Improvement Activities		
11. Program Integrity Activities		
12. TOTAL ADMINISTRATION (Items 3-12)		
14. TOTAL EXPENSES		
15. INCOME (LOSS)		
16. Extraordinary Income (Loss)		
17. Provision for Taxes		
18. Licensing Fees		
19. Regulatory Fees		
20. Remittances Owed to the State (if applicable)		
21. NET INCOME (LOSS)		
22. LOSS RATIO (Item 15/Item 21)		
23. Credibility Adjustment (if applicable)		
24. Adjusted LOSS RATIO		
Methodology for Allocation of Expenditures:		

2. Provider Monitoring Report (Exhibit A, Attachment 5, Provision K, Subprovision 4)

<u>Provider Monitoring Report</u>
<p>Provider: Doe, Jane DDS Provider NPI: 0123456789 Dental Plan Name: Space Dental Reviewed by: Smith, John and Frost, Jack DDS</p> <p><u>Service Site Audit Findings:</u> Overall Results: 80%</p> <p>-Emergency Appointment time A request from a member's parent for an appointment for her child experiencing tooth pain was not acknowledged within the appropriate timeframe and therefore the appointment was not made within 48 hours, as required.</p> <p><u>Dental Record (Chart) Audit Findings:</u> Overall Results: 80%</p> <p>-X amount of charts did not have Dr. Doe's signature and were not dated</p> <p><u>Utilization Review of Encounter Data:</u> Overall Results: 50%</p> <p>-Encounter Data for the 6 out of the 12 months of the past year not submitted</p> <p><u>Corrective Action Plan:</u> Corrective Action Plan required for these items. Will follow-up in 6 months. <i>[Details of Corrective Action Plan need to be stated here]</i></p>

3. Specialty Referrals Report (Exhibit A, Attachment 11, Provision B, Subprovision 5)

SPECIALTY REFERRALS REPORT				
Plan Name:	Space Dental			
Reporting Quarter:	Q1 of 2012			
Number of Referrals Requested	Number of Benes Referred	Number of Benes seen within 30 days	Number of Benes seen within 60 days	Number of Referrals Expired without Benes being seen
65	50	25	10	20

4. Call Center Report (Exhibit A, Attachment 14, Provision C)

CALL CENTER REPORT						
Plan Name: _____						
Reporting Quarter: _____						
Type of Calls	Questions on Benefits	Provider Information	Access to Services	Grievance	Health Education	Specialty Referrals
Number of Calls						
Average Speed of Answering Calls						
Calls Abandonment Rate						
"P" Factor*						
* "P" Factor: The percentage of connected calls versus non-connected calls and/or busy signals						

[illegible]

Changes to Space Dental's Provider Network

*HFP ; Healthy Families Program

7. Corrective Action Plan (Exhibit A, Attachment 5, Provision N)

CORRECTIVE ACTION PLAN	
Plan Name:	Space Dental
Contract #:	13-XXXXXX
Contact Name:	John Allen
Date:	
Prepared by:	John Smith
Encounter Data:	
Issue:	
Recommendation:	
Key Milestones:	
Success Measure:	
Please Do Not Write Below This Line	
MDSD Approval:	Management Approval:
MDSD Denied:	
Reviewed By:	
MDSD Comments:	

8. Timely Access Report (Exhibit A, Attachment 11, Provision B, Subprovision 3)

Appointment Times

Plan Name:		Reporting Period:		Quarter 1 of 2013													
Business Name	Provider Full Name	Address	City	State	Zip	PhoneNum ber	Appointment for New Members (#	Appointm ent (# of Days)	Appointme nt (# of Days)	Emergency Visit (# of Days)	No Show Appointm ents	Number of Rescheduled Appointments	Interpreter Services Available?	Answering Service available?	Members to Primary Care Dentist	Members to Primary Care Dentist	
John Doe Dental	John Doe	123 Murry Lane	Sacramento	CA	95823	916-555-1234	25	15	15	1	26	12	Yes	Yes	1 to 64	1 to 64	

Plan Name: Space Dental
Reporting Period: Quarter 1 of 2013
Number of Members who are assigned to a Primary Care Dentist who is more than 30 minutes or more than 10 miles from their residence:
45

Plan Name: Space Dental
Reporting Period: Quarter 1 of 2013
Number of Routine Authorizations approved within 5 business days:
24
Number of Routine Authorizations approved within 10 business days:
12
Number of Routine Authorizations approved outside of 10 business days:
15
Percentage of Claims Paid Within 90 Days:
99%
Percentage of Claims Paid outside of 90 days:
1%

Exhibit B
Budget Detail and Payment Provisions

Clause Index

Index of numbered clauses in **Exhibit B**

1. Budget Contingency Clause
2. Contractor Risk in Providing Services
3. Capitation Payment
4. Capitation Rates Constitute payments in full
5. Determination of Rates
6. Redetermination of Rates – Obligation changes
7. Reinsurance
8. Catastrophic Coverage Limitation
9. Financial Performance Guarantee
10. Recovery of Capitation Payments
11. Health Insurance Provider Fee (HIPF)

Exhibit B
Budget Detail and Payment Provisions**A. Budget Contingency Clause**

1. It is mutually agreed that if the Budget Act of the current year and/or any subsequent years covered under this Agreement does not appropriate sufficient funds for the program, this Agreement shall be of no further force and effect. In this event, DHCS shall have no liability to pay any funds whatsoever to Contractor or to furnish any other considerations under this Agreement and Contractor shall not be obligated to perform any provisions of this Agreement.
2. If funding for any fiscal year is reduced or deleted by the Budget Act for purposes of this program, DHCS shall have the option to either cancel this Agreement with no liability occurring to DHCS, or offer an agreement amendment to Contractor to reflect the reduced amount.

B. Contractor Risk In Providing Services

Contractor will assume the total risk of providing the covered services on the basis of the periodic capitation payment for each Member, except as otherwise allowed in this contract. Any monies not expended by the Contractor after having fulfilled obligations under this contract will be retained by the Contractor.

C. Capitation Payment

1. Capitation Payment

DHCS shall remit to Contractor a monthly capitation payment for each Medi-Cal Member that appears on the approved list of Members supplied to Contractor by DHCS. The payment period for health care services shall commence on the first day of the Operations Period. Capitation payments in the amount of \$8.42 for adults and \$11.45 for children shall be paid at the end of the month for the month of service, subject to provisions E and F of this Exhibit. **Payments are only to be made by the State and retained by the Contractor for Medi-Cal eligible Members.**

2. Derivative Aid Code Updates

If DHCS creates a new aid code that is split or derived from an existing aid code covered under this contract, and the aid code has a neutral revenue effect for the Contractor, then the split aid code will automatically be included in the same aid code rate group as the original aid code covered under this contract. Contractor agrees to continue providing covered services to the Members at the monthly capitation rate specified for the original aid code. DHCS shall confirm all aid code splits in writing to Contractor as soon as practicable after such aid code splits occur.

3. Payment Withhold

DHCS will withhold thirteen (13) percent of the monthly capitation payment commencing with the first month payment of the Operations Period and continuing until the end of the Operations Period. The withheld funds will be allocated to the following payment categories and reserved for future payment to the Contractor upon successful completion of their annual performance evaluation:

- a. Performance Measures: 10 percent

- b. Deliverables: 3 percent

4. Payment of Withheld Funds

- a. Payment of the ten (10) percent monthly withheld funds shall be payable upon the completion of the annual performance evaluation and is subject to Contractor's ability to meet or exceed established benchmarks for specific performance measures during the measurement year. DHCS will evaluate the Contractor's performance on an annual basis which shall commence six (6) months following the end of the measurement year in order to take into account all encounter data submissions for the prior six (6) months. Points will be awarded at the end of the performance evaluation period. The percentage of the retained amount payable to the Contractor will be determined by the points table. (See Exhibit A, Attachment 6, Performance Measures and Benchmarks) Upon completion of the performance evaluation, DHCS will notify plans in writing within ten (10) business days of the evaluation results.
- b. Three (3) percent payment of withheld funds shall be payable at the end of the measurement year and is subject to the Contractor's ability to submit deliverables timely and accurately. Deliverables must be submitted according to Exhibit A, Attachment 19, Deliverable Schedule. At the end of the measurement year, DHCS will determine the amount of the three (3) percent withhold as appropriate, and notify plans in writing of the release within ten (10) business days.

5. Determination of Performance

a. Performance Measures

Payment of the ten (10) percent monthly withhold of the Contractor's capitation shall be contingent upon meeting or exceeding the annual established benchmarks for specific performance measures. Each performance measure will be allocated a benchmark threshold. Each threshold will be assigned points. Contractor must meet or exceed the benchmark threshold to be awarded the maximum points. (See Exhibit A, Attachment 6, Performance Measures and Benchmarks)

- 1) The Contractor's performance will be evaluated on an annual basis which shall commence six (6) months following the end of the measurement year.

For each succeeding contract year, the performance measurement year will commence on January 1st and continue for twelve (12) months.

b. Deliverables

Payment of the three (3) percent monthly withhold of the Contractor's capitation shall be contingent upon submitting timely and accurate deliverables based upon Exhibit A, Attachment 19, Deliverable Schedule.

Each deliverable submitted to DHCS will be reviewed for timeliness and accuracy of the information per contract provisions.

6. Bonus Payment

Contractor will have the ability to earn a portion of the five (5) percent bonus above the capitation payment for exceptional performance in concentrated age categories. The bonus will be based on the Contractor's performance measures meeting the bonus benchmark threshold for those age groups. (See Exhibit A, Attachment 6, Performance Measures and Benchmarks)

DHCS will identify the Contractors who have met the bonus benchmarks six (6) months following the end of the measurement year. DHCS will notify plans that qualified for the five (5) percent bonus payment in writing within ten (10) business days.

At no time will the capitation payment (including the withhold payment) combined with the bonus payment, exceed 105% of the capitation payment to the Contractors.

- a. Incentive arrangements are for a fixed period of time and performance is measured during the rating period under the contract in which the incentive arrangement is applied.
- b. Incentive arrangements are not renewed automatically.
- c. Incentive arrangements are made available to both public and private Contractors under the same terms of performance.
- d. Contractor participation in an incentive arrangement does not require Contractor to enter into or adhere to intergovernmental transfer agreements.

7. Failure to Perform

- a. DHCS will continually monitor Contractor's compliance with contract requirements. In the event Contractor fails to meet specific requirements, Contractor will have the opportunity to correct the performance standard or deliverable.
 - 1) DHCS will notify Contractor in writing if the Contractor is at risk of not meeting a specific obligation.
 - 2) Contractor will be required to submit a CAP, pending DHCS' request, for any requirement that is not met or for deliverables that are not received by DHCS.
 - 3) DHCS will work closely with Contractor to monitor and assist Contractor in meeting all requirements.
- b. If Contractor is not able to meet or exceed contract performance requirements, Provision C, Subprovision 4, Payment of Withheld Funds, will apply.
- c. DHCS shall have sole discretion in approving any standard or deliverable that is deemed in compliance and considered timely.
- d. In the event Contractor is consistently not able to meet the performance measures, DHCS reserves the right to halt all new enrollments and/or terminate the contract.

8. Interest on Withheld Funds

Interest will not be paid to Contractor for funds withheld by DHCS. Any funds withheld by DHCS pursuant to this Provision C that does not meet the standard described in Subprovision 9, Verification Reviews will not be reimbursed to Contractor.

9. Verification Reviews

Contractor performance in meeting the standards will be subject to verification reviews by DHCS. Should it be determined based on a verification review that Contractor did not actually meet the standard or that Member dental records do not document the services reported, DHCS will recover any payments made to Contractor for meeting the standard. Contractor shall cooperate fully with DHCS in the verification review and furnish all necessary records and information required by DHCS to complete the review.

D. Capitation Rates Constitute Payment In Full

The capitation rate for each rate period, as calculated by DHCS, are prospective rates and constitute payment in full subject to any stop loss reinsurance by the State on behalf of a Member for all covered services required by the Member and for all administrative costs incurred by the Contractor in providing or arranging for those services. It does not include payment for the recoupment of current or previous losses incurred by Contractor. DHCS is not responsible for making payments for recoupment of losses.

E. Determination of Rates

1. DHCS shall determine the capitation rates for the initial period of Operations, through the duration of the contract. DHCS shall make an annual redetermination of rates in accordance with Title 22 CCR Sections 53321 and 53322 for each rate year defined as the 12-month period from July 1 through June 30. DHCS reserves the right to establish rates on an actuarial basis for each rate year. All payments and rate adjustments are subject to appropriations of funds by the Legislature and the Department of Finance approval. Further, all payments are subject to the availability of Federal congressional appropriation of funds.
2. **DHCS shall determine capitation rates in accordance with 42 CFR § 438.4 and 42 CFR § 438.5.**
3. **DHCS shall ensure that the capitation payment minus any portion of the withhold that is not reasonably achievable is actuarially sound as determined by an actuary. The total amount of the withhold, achievable or not, must be reasonable and take into consideration the Contractor's financial operating needs accounting for the size and characteristics of the populations covered under the contract, as well as the Contractor's capital reserves as measured by the risk-based capital level, months of claims reserve, or other appropriate measure of reserves. The data, assumptions, and methodologies used to determine the portion of the withhold that is reasonably achievable must be submitted as part of the documentation required under 42 CFR § 438.7(b)(6).**

- 42.** Once DHCS establishes rates on an actuarially sound basis, it shall determine whether the rates shall be increased, decreased, or remain the same. If it is determined by DHCS that Contractor's capitation rates shall be increased or decreased, the increase or decrease shall be effectuated through a contract amendment to this contract in accordance with Exhibit E, Additional Provisions, Provision 8, Change Requirements, subject to the following provisions:
- a. The contract amendment shall be effective as of July 1 of each year covered by this contract or as stipulated by changes in Legislation or Regulation.
 - b. In the event there is any delay in a determination to increase or decrease capitation rates, so that a contract amendment may not be processed in time to permit payment of new rates commencing July 1, the payment to Contractor shall continue at the rates then in effect. Those continued payments shall constitute interim payment only. Upon final approval of the contract amendment providing for the rate change, DHCS shall make retroactive adjustments for those months for which interim payment was made.
 - c. By accepting payment of new annual rates prior to full approval by all control agencies of the contract amendment to this Contract implementing such new rates, Contractor stipulates to a confession of judgment for any amounts received in excess of the final approved rate. If the final approved rate differs from the rates established by DHCS or agreed upon by Contractor and DHCS:
 - 1) Any underpayment by the State shall be paid to Contractor within thirty (30) calendar days after final approval of the new rates.
 - 2) Any overpayment to Contractor shall be recaptured by DHCS withholding the amount due from Contractor's next capitation check. If the amount to be withheld from that capitation check exceeds twenty-five (25) percent of the capitation payment for that month, amounts up to twenty-five (25) percent shall be withheld from successive capitation payments until the overpayment is fully recovered by the DHCS. At least thirty (30) calendar days prior to seeking such recovery, DHCS shall inform Contractor of the overpayment.
 - 3) Contractor shall report to the State within 60 calendar days when the Contractor identified the capitation payments or other payments in excess of amounts specified in the contract.**
 - d. If mutual agreement between DHCS and Contractor cannot be attained on capitation rates for rate years subsequent to January 1, 2013 resulting from a rate change pursuant to this Provision E or Provision F below, Contractor shall retain the right to terminate the contract, in accordance with Exhibit E, Additional Provisions, Provision 3, Termination. Notification of intent to terminate a contract shall be in writing and provided to DHCS at least nine (9) months prior to the effective date of termination, subject to any earlier termination date negotiated in accordance with Exhibit E, Additional Provisions, Provision 3, regarding Termination. DHCS shall pay the capitation rates last offered for that rate period until the contract is terminated.

- e. DHCS shall make every effort to notify and consult with Contractor regarding proposed redetermination of rates pursuant to this section or Provision F below, at the earliest possible time prior to implementation of the new rate.

F. Redetermination of Rates - Obligation Changes

The capitation rates may be adjusted during the rate year to provide for a change in obligations that results in an increase or decrease of more than one (1) percent of cost (as defined in Title 22 CCR Section 53322) to the Contractor. Any adjustments shall be effectuated through a contract amendment to the contract subject to the following provisions:

1. The contract amendment shall be effective as of the first day of the month in which the change in obligations is effective, as determined by DHCS.
2. In the event DHCS is unable to process the contract amendment in time to permit payment of the adjusted rates as of the month in which the change in obligations is effective, payment to Contractor shall continue at the rates then in effect. Continued payment shall constitute interim payment only. Upon final approval of the contract amendment providing for the change in obligations, DHCS shall make adjustments for those months for which interim payment was made.
3. DHCS and Contractor may negotiate an earlier termination date, pursuant to Exhibit E, Additional Provisions, Provision 3, Termination – Contractor, if a change in contractual obligations is created by a State or Federal change in the Medi-Cal program, or a lawsuit, that substantially alters the financial assumptions and conditions under which Contractor entered into this contract, such that Contractor can demonstrate to the satisfaction of DHCS that it cannot remain financially solvent until the termination date that would otherwise be established under this provision. Notification of intent to terminate a contract shall be in writing and provided to DHCS at least nine (9) months prior to the effective date of termination, subject to any earlier termination date negotiated in accordance with Exhibit E, Additional Provisions, Provision 3, Termination – Contractor. DHCS shall pay the capitation rates last offered for that rate period until the contract is terminated.

G. Reinsurance

Contractor may obtain reinsurance (stop loss coverage) to ensure maintenance of adequate capital by Contractor for the cost of providing covered services under this contract. Pursuant to Title 22 CCR Section 53252 (a)(2)(A)&(B), reinsurance will not limit the Contractor's liability below \$5,000 per Member for any 12-month period as specified by DHCS, and Contractor may obtain reinsurance for the total cost of services provided to Members by non-contractor emergency service providers and for ninety (90) percent of all costs exceeding one hundred fifteen (115) percent of its income during any Contractor fiscal year.

H. Catastrophic Coverage Limitation

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

I. Financial Performance Guarantee

Contractor shall provide satisfactory evidence of and maintain financial performance guarantee in an amount equal to at least one month's capitation payment, in a manner specified by DHCS. At the Contractor's request, and with DHCS approval, Contractor may establish a phase-in schedule to accumulate the required financial performance guarantee. Contractor may elect to satisfy the financial performance guarantee requirement by receiving payment on a post payment basis. The financial performance guarantee shall remain in effect for a period not exceeding ninety (90) calendar days following termination or expiration of this contract or unless DHCS has a financial claim against Contractor. Further rights and obligations of the Contractor and DHCS, in regards to financial Performance guarantee, shall be as specified in 22 CCR 53865.

J. Recovery Of Capitation Payments

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

1. If DHCS determines that a Member has either been improperly enrolled due to ineligibility of the Member to enroll in Contractor's plan, residence outside of contractor's service area, or should have been disenrolled with an effective date in a prior month, DHCS may recover the capitation payments made to Contractor for the Member. In such event, Contractor may seek to recover any payments made to providers for covered services rendered for the month(s) in question. Contractor shall inform providers that claims for services provided to Members during the month(s) in question shall be paid by DHCS fiscal intermediary, if the Member is determined eligible for the Medi-Cal program.

Upon request by Contractor, DHCS may allow Contractor to retain the capitation payments made for Members that are eligible to enroll in Contractor's plan, but should have been retroactively disenrolled or under other circumstances as approved by DHCS. If Contractor retains the capitation payments, Contractor shall provide or arrange and pay for all Necessary Dental Covered Services for the Member, until the Member is disenrolled on a non-retroactive basis pursuant to Exhibit A, Attachment 16, Provision D, Disenrollment.

2. As a result of Contractor's failure to perform contractual responsibilities to comply with mandatory federal Medicaid requirements, the Federal Department of Health and Human Services (DHHS) may disallow Federal Financial Participation (FFP) for payments made by DHCS to Contractor. DHCS may recover the amounts disallowed by DHHS by an offset to the capitation payments made to Contractor. At least thirty (30) calendar days prior to seeking such recovery, DHCS shall inform Contractor about the improper payment, and the overpayment to Contractor shall be recaptured by DHCS withholding the amount due from Contractor's next capitation check. If the amount to be withheld from that capitation check exceeds twenty-five (25) percent of the capitation payment for that month, amounts up to twenty-five (25) percent shall be withheld from successive capitation payments until the overpayment is fully recovered by DHCS.
3. If DHCS determines that an improper payment was received by Contractor for any reason not referenced in Subprovision 1 or 2, which may include, but is not limited to, error, mistake, omission, inadvertence, delay or neglect on the part of DHCS or other entity or person, DHCS may recover the amounts determined by an offset to the capitation payments made to Contractor in accordance with Welfare and Institutions Code Section 14115.5. At least thirty (30) calendar days prior to seeking such recovery, DHCS shall inform Contractor about the improper payment, and the overpayment to Contractor shall be recaptured by DHCS withholding the amount due from Contractor's next capitation check. If the amount to be

withheld from that capitation check exceeds twenty-five (25) percent of the capitation payment for that month, amounts up to twenty-five (25) percent shall be withheld from successive capitation payments until the overpayment is fully recovered by DHCS.

K. Health Insurance Provider Fee

1. Annually, DHCS shall request the Contractor (not exempt from HIPF) to provide DHCS the following information:
 - a. Confirmation that the Contractor is subject to the Health Insurance Providers Fee (HIPF).
 - b. A copy of the Contractor's submitted Internal Revenue Service (IRS) Form 8963.
 - c. A copy of the Contractor's preliminary fee notice from the IRS.
2. The HIPF dollars paid by the plans in the current year vary as a percentage of the Contractor's previous Calendar Year (CY) premiums, so Medi-Cal premiums for the previous calendar year coverage are utilized to calculate the premium adjustment for the HIPF and related taxes.
3. DHCS will include the HIPF adjustments in the calendar fee year as per member per month (PMPM) adjustments to the dental premium for non-affordable care act (ACA) expansion population only. The ACA expansion did not take effect until January 1, 2014; therefore, ACA expansion population is not subject to the 2014 HIPF adjustments.
4. The HIPF add-ons are grossed up for all applicable corporate taxes. Based on research of California (CA) tax law, the Franchise Tax Board (FTB) has determined that the HIPF is deductible for state income tax purposes. The HIPF calculation takes this deduction into account.
5. HIPF rates and add-ons for non-ACA expansion population will be provided to the Contractor as a rate package for the following rate periods:
 - a. 13/14 rates 1/2014 - 4/2014: with Assembly Bill (AB) 97 before adult benefit restoration
 - b. 13/14 rates 5/2014 - 6/2014: with AB97 and adult benefit restoration
 - c. 14/15 rates 7/2014 - 12/2014: with AB97 and adult benefit restoration
 - d. 14/15 rates 1/2015 – 6/2015: with AB97 and adult benefit restoration

Rate Term	Dates	Rates Package Title	HIPF Year	HIPF Rate
13/14	1/2014-4/2014	Assembly Bill (AB) 97 before adult benefit restoration	2014	0.04
13/14	5/2014-6/2014	AB97 and adult benefit restoration	2014	0.04
<u>14/15</u>	<u>7/2014-12/2014</u>	<u>AB97 and adult benefit restoration</u>	<u>2014</u>	<u>0.04</u>
14/15	1/2015- 6/2015	AB97 and adult benefit restoration	2015	0.26

6. The 2014 HIPF add-on for non-ACA expansion population is \$0.04 for July 1, 2014 through December 31, 2014.
7. The 2015 HIPF add on for non – ACA expansion is \$0.26 for January 1, 2015 through June 30, 2015.

Exhibit C
General Terms and Conditions

This page is a place holder for Exhibit C.

The State's General Terms and Conditions (GTC 610) can only be viewed or downloaded from the following Internet site: <http://www.ols.dgs.ca.gov/Standard Language/default.htm>.

The State's General Terms and Conditions are modified from time to time by the California Department of General Services to comply with changes to federal or state law and the version that applies to the resulting agreement is determined based on the contract start date. DHCS reserves the right to place into the resulting agreement a more current GTC version, when applicable.

If a bidding firm does not have Internet access they are to contact the program identified in the bid cover letter to request a hard or paper copy of the State's General Term and Conditions.

Special Terms and Conditions

(For federally funded service contracts or agreements and grant agreements)

The use of headings or titles throughout this exhibit is for convenience only and shall not be used to interpret or to govern the meaning of any specific term or condition.

The terms "contract", "Contractor" and "Subcontractor" shall also mean, "agreement", "grant", "grant agreement", "Grantee" and "Subgrantee" respectively.

The terms "California Department of Health Care Services", "California Department of Health Services", "Department of Health Care Services", "Department of Health Services", "CDHCS", "DHCS", "CDHS", and "DHS" shall all have the same meaning and refer to the California State agency that is a party to this Agreement.

This exhibit contains provisions that require strict adherence to various contracting laws and policies. Some provisions herein are conditional and only apply if specified conditions exist (i.e., agreement total exceeds a certain amount; agreement is federally funded, etc.). The provisions herein apply to this Agreement unless the provisions are removed by reference on the face of this Agreement, the provisions are superseded by an alternate provision appearing elsewhere in this Agreement, or the applicable conditions do not exist.

Index of Special Terms and Conditions

1. Federal Equal Employment Opportunity Requirements	17. Human Subjects Use Requirements
2. Travel and Per Diem Reimbursement	18. Novation Requirements
3. Procurement Rules	19. Debarment and Suspension Certification
4. Equipment Ownership / Inventory /Disposition	20. Smoke-Free Workplace Certification
5. Subcontract Requirements	21. Covenant Against Contingent Fees
6. Income Restrictions	22. Payment Withholds
7. Audit and Record Retention	23. Performance Evaluation
8. Site Inspection	24. Officials Not to Benefit
9. Federal Contract Funds	25. Four-Digit Date Compliance
10. Intellectual Property Rights	26. Prohibited Use of State Funds for Software
11. Air or Water Pollution Requirements	27. Use of Small, Minority Owned and Women's Businesses
12. Prior Approval of Training Seminars, Workshops or Conferences	28. Alien Ineligibility Certification
13. Confidentiality of Information	29. Union Organizing
14. Documents, Publications, and Written Reports	30. Contract Uniformity (Fringe Benefit Allowability)
15. Dispute Resolution Process (Revised 2/2012)	31. Suspension or Stop Work Notification
16. Financial and Compliance Audit Requirements	32. Lobbying Restrictions and Disclosure Certification

1. Federal Equal Opportunity Requirements

(Applicable to all federally funded agreements entered into by the Department of Health Care Services)

- a. The Contractor will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. The Contractor will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. The Contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973 and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212). Such notices shall state the Contractor's obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.
- b. The Contractor will, in all solicitations or advancements for employees placed by or on behalf of the Contractor, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.
- c. The Contractor will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of the Contractor's commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.
- d. The Contractor will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, „Amending Executive Order 11246 Relating to Equal Employment Opportunity,, and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.
- e. The Contractor will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, „Amending Executive Order 11246 Relating to Equal Employment Opportunity,, and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.
- f. In the event of the Contractor's noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this Agreement may be cancelled, terminated, or suspended in whole or in part and the Contractor may be declared ineligible for further federal and state contracts in accordance with procedures authorized in Federal Executive Order No. 11246 as amended and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, „Amending Executive Order 11246 Relating to Equal Employment Opportunity,, and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided bylaw.

- g. The Contractor will include the provisions of Paragraphs a through g in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, „Amending Executive Order 11246 Relating to Equal Employment Opportunity,, and as supplemented by regulation at 41 CFR part 60, “Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor,” or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each subcontractor or vendor. The Contractor will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions including sanctions for noncompliance provided, however, that in the event the Contractor becomes involved in, or is threatened with litigation by a subcontractor or vendor as a result of such direction by DHCS, the Contractor may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

2. Travel and Per Diem Reimbursement

(Applicable if travel and/or per diem expenses are reimbursed with agreement funds.)

Reimbursement for travel and per diem expenses from DHCS under this Agreement shall, unless otherwise specified in this Agreement, be at the rates currently in effect, as established by the California Department of Personnel Administration (DPA), for nonrepresented state employees as stipulated in DHCS" Travel Reimbursement Information Exhibit. If the DPA rates change during the term of the Agreement, the new rates shall apply upon their effective date and no amendment to this Agreement shall be necessary. Exceptions to DPA rates may be approved by DHCS upon the submission of a statement by the Contractor indicating that such rates are not available to the Contractor. No travel outside the State of California shall be reimbursed without prior authorization from DHCS. Verbal authorization should be confirmed in writing. Written authorization may be in a form including fax or email confirmation.

3. Procurement Rules

(Applicable to agreements in which equipment/property, commodities and/or supplies are furnished by DHCS or expenses for said items are reimbursed by DHCS with state or federal funds provided under the Agreement.)

a. Equipment/Property definitions

Wherever the term equipment and/or property is used, the following definitions shall apply:

- (1) **Major equipment/property:** A tangible or intangible item having a base unit cost of \$5,000 or more with a life expectancy of one (1) year or more and is either furnished by DHCS or the cost is reimbursed through this Agreement. Software and videos are examples of intangible items that meet this definition.
 - (2) **Minor equipment/property:** A tangible item having a base unit cost of less than \$5,000 with a life expectancy of one (1) year or more and is either furnished by DHCS or the cost is reimbursed through this Agreement.
- b. **Government and public entities** (including state colleges/universities and auxiliary organizations), whether acting as a contractor and/or subcontractor, may secure all commodities, supplies, equipment and services related to such purchases that are required in performance of this Agreement. Said procurements are subject to Paragraphs d through h of Provision 3. Paragraph c of Provision 3 shall also apply, if equipment/property purchases are delegated to subcontractors that are nonprofit organizations or commercial businesses.
 - c. **Nonprofit organizations and commercial businesses**, whether acting as a contractor and/or subcontractor, may secure commodities, supplies, equipment/property and services related to such purchases for performance under this Agreement.
 - (1) Equipment/property purchases shall not exceed \$50,000 annually.

To secure equipment/property above the annual maximum limit of \$50,000, the Contractor shall

make arrangements through the appropriate DHCS Program Contract Manager, to have all remaining equipment/property purchased through DHCS' Purchasing Unit. The cost of equipment/property purchased by or through DHCS shall be deducted from the funds available in this Agreement. Contractor shall submit to the DHCS Program Contract Manager a list of equipment/property specifications for those items that the State must procure. DHCS may pay the vendor directly for such arranged equipment/property purchases and title to the equipment/property will remain with DHCS. The equipment/property will be delivered to the Contractor's address, as stated on the face of the Agreement, unless the Contractor notifies the DHCS Program Contract Manager, in writing, of an alternate delivery address.

- (2) All equipment/property purchases are subject to Paragraphs d through h of Provision 3. Paragraph b of Provision 3 shall also apply, if equipment/property purchases are delegated to subcontractors that are either a government or public entity.
- (3) Nonprofit organizations and commercial businesses shall use a procurement system that meets the following standards:
 - (a) Maintain a code or standard of conduct that shall govern the performance of its officers, employees, or agents engaged in awarding procurement contracts. No employee, officer, or agent shall participate in the selection, award, or administration of a procurement, or bid contract in which, to his or her knowledge, he or she has a financial interest.
 - (b) Procurements shall be conducted in a manner that provides, to the maximum extent practical, open, and free competition.
 - (c) Procurements shall be conducted in a manner that provides for all of the following:
 - [1] Avoid purchasing unnecessary or duplicate items.
 - [2] Equipment/property solicitations shall be based upon a clear and accurate description of the technical requirements of the goods to be procured.
 - [3] Take positive steps to utilize small and veteran owned businesses.
- d. Unless waived or otherwise stipulated in writing by DHCS, prior written authorization from the appropriate DHCS Program Contract Manager will be required before the Contractor will be reimbursed for any purchase of \$5,000 or more for commodities, supplies, equipment/property, and services related to such purchases. The Contractor must provide in its request for authorization all particulars necessary, as specified by DHCS, for evaluating the necessity or desirability of incurring such costs. The term "purchase" excludes the purchase of services from a subcontractor and public utility services at rates established for uniform applicability to the general public.
- e. In special circumstances, determined by DHCS (e.g., when DHCS has a need to monitor certain purchases, etc.), DHCS may require prior written authorization and/or the submission of paid vendor receipts for any purchase, regardless of dollar amount. DHCS reserves the right to either deny claims for reimbursement or to request repayment for any Contractor and/or subcontractor purchase that DHCS determines to be unnecessary in carrying out performance under this Agreement.
- f. The Contractor and/or subcontractor must maintain a copy or narrative description of the procurement system, guidelines, rules, or regulations that will be used to make purchases under this Agreement. The State reserves the right to request a copy of these documents and to inspect the purchasing practices of the Contractor and/or subcontractor at anytime.
- g. For all purchases, the Contractor and/or subcontractor must maintain copies of all paid vendor invoices, documents, bids and other information used in vendor selection, for inspection or audit. Justifications supporting the absence of bidding (i.e., sole source purchases) shall also be maintained on file by the Contractor and/or subcontractor for inspection or audit.
- h. DHCS may, with cause (e.g., with reasonable suspicion of unnecessary purchases or use of inappropriate purchase practices, etc.), withhold, cancel, modify, or retract the delegated purchase authority granted under Paragraphs b and/or c of Provision 3 by giving the Contractor no less than 30 calendar days written notice.

4. Equipment/Property Ownership / Inventory /Disposition

(Applicable to agreements in which equipment/property is furnished by DHCS and/or when said items are purchased or reimbursed by DHCS with state or federal funds provided under the Agreement.)

- a. Wherever the term equipment and/or property is used in Provision 4, the definitions in Paragraph a of Provision 3 shall apply.

Unless otherwise stipulated in this Agreement, all equipment and/or property that is purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement shall be considered state equipment and the property of DHCS.

- (1) **Reporting of Equipment/Property Receipt** - DHCS requires the reporting, tagging and annual inventorying of all equipment and/or property that is furnished by DHCS or purchased/reimbursed with funds provided through this Agreement.

Upon receipt of equipment and/or property, the Contractor shall report the receipt to the DHCS Program Contract Manager. To report the receipt of said items and to receive property tags, Contractor shall use a form or format designated by DHCS" Asset Management Unit. If the appropriate form (i.e., Contractor Equipment Purchased with DHCS Funds) does not accompany this Agreement, Contractor shall request a copy from the DHCS Program Contract Manager.

- (2) **Annual Equipment/Property Inventory** - If the Contractor enters into an agreement with a term of more than twelve months, the Contractor shall submit an annual inventory of state equipment and/or property to the DHCS Program Contract Manager using a form or format designated by DHCS" Asset Management Unit. If an inventory report form (i.e., Inventory/Disposition of DHCS-Funded Equipment) does not accompany this Agreement, Contractor shall request a copy from the DHCS Program Contract Manager. Contractor shall:

- (a) Include in the inventory report, equipment and/or property in the Contractor's possession and/or in the possession of a subcontractor (including independent consultants).
 - (b) Submit the inventory report to DHCS according to the instructions appearing on the inventory form or issued by the DHCS Program Contract Manager.
 - (c) Contact the DHCS Program Contract Manager to learn how to remove, trade-in, sell, transfer or survey off, from the inventory report, expired equipment and/or property that is no longer wanted, usable or has passed its life expectancy. Instructions will be supplied by either the DHCS Program Contract Manager or DHCS" Asset Management Unit.
- b. Title to state equipment and/or property shall not be affected by its incorporation or attachment to any property not owned by the State.
 - c. Unless otherwise stipulated, DHCS shall be under no obligation to pay the cost of restoration, or rehabilitation of the Contractor's and/or Subcontractor's facility which may be affected by the removal of any state equipment and/or property.
 - d. The Contractor and/or Subcontractor shall maintain and administer a sound business program for ensuring the proper use, maintenance, repair, protection, insurance and preservation of state equipment and/or property.
 - (1) In administering this provision, DHCS may require the Contractor and/or Subcontractor to repair or replace, to DHCS" satisfaction, any damaged, lost or stolen state equipment and/or property. In the event of state equipment and/or miscellaneous property theft, Contractor and/or Subcontractor shall immediately file a theft report with the appropriate police agency or the California Highway Patrol and Contractor shall promptly submit one copy of the theft report to the DHCS Program Contract Manager.
 - e. Unless otherwise stipulated by the Program funding this Agreement, equipment and/or property purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, shall only be used for performance of this Agreement or another DHCS agreement.

- f. Within sixty (60) calendar days prior to the termination or end of this Agreement, the Contractor shall provide a final inventory report of equipment and/or property to the DHCS Program Contract Manager and shall, at that time, query DHCS as to the requirements, including the manner and method, of returning state equipment and/or property to DHCS. Final disposition of equipment and/or property shall be at DHCS expense and according to DHCS instructions. Equipment and/or property disposition instructions shall be issued by DHCS immediately after receipt of the final inventory report. At the termination or conclusion of this Agreement, DHCS may at its discretion, authorize the continued use of state equipment and/or property for performance of work under a different DHCS agreement.

g. Motor Vehicles

(Applicable only if motor vehicles are purchased/reimbursed with agreement funds or furnished by DHCS under this Agreement.)

- (1) If motor vehicles are purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, within thirty (30) calendar days prior to the termination or end of this Agreement, the Contractor and/or Subcontractor shall return such vehicles to DHCS and shall deliver all necessary documents of title or registration to enable the proper transfer of a marketable title to DHCS.
- (2) If motor vehicles are purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, the State of California shall be the legal owner of said motor vehicles and the Contractor shall be the registered owner. The Contractor and/or a subcontractor may only use said vehicles for performance and under the terms of this Agreement.
- (3) The Contractor and/or Subcontractor agree that all operators of motor vehicles, purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, shall hold a valid State of California driver's license. In the event that ten or more passengers are to be transported in any one vehicle, the operator shall also hold a State of California Class B driver's license.
- (4) If any motor vehicle is purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, the Contractor and/or Subcontractor, as applicable, shall provide, maintain, and certify that, at a minimum, the following type and amount of automobile liability insurance is in effect during the term of this Agreement or any extension period during which any vehicle remains in the Contractor's and/or Subcontractor's possession:

Automobile Liability Insurance

- (a) The Contractor, by signing this Agreement, hereby certifies that it possesses or will obtain automobile liability insurance in the amount of \$1,000,000 per occurrence for bodily injury and property damage combined. Said insurance must be obtained and made effective upon the delivery date of any motor vehicle, purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, to the Contractor and/or Subcontractor.
- (b) The Contractor and/or Subcontractor shall, as soon as practical, furnish a copy of the certificate of insurance to the DHCS Program Contract Manager. The certificate of insurance shall identify the DHCS contract or agreement number for which the insurance applies.
- (c) The Contractor and/or Subcontractor agree that bodily injury and property damage liability insurance, as required herein, shall remain in effect at all times during the term of this Agreement or until such time as the motor vehicle is returned to DHCS.
- (d) The Contractor and/or Subcontractor agree to provide, at least thirty (30) days prior to the expiration date of said insurance coverage, a copy of a new certificate of insurance evidencing continued coverage, as indicated herein, for not less than the remainder of the term of this Agreement, the term of any extension or continuation thereof, or for a period of not less than one (1) year.
- (e) The Contractor and/or Subcontractor, if not a self-insured government and/or public entity, must provide evidence, that any required certificates of insurance contain the following provisions:

- [1] The insurer will not cancel the insured's coverage without giving thirty (30) calendar days prior written notice to the State (California Department of Health Care Services).
 - [2] The State of California, its officers, agents, employees, and servants are included as additional insureds, but only with respect to work performed for the State under this Agreement and any extension or continuation of this Agreement.
 - [3] The insurance carrier shall notify the California Department of Health Care Services (DHCS), in writing, of the Contractor's failure to pay premiums; its cancellation of such policies; or any other substantial change, including, but not limited to, the status, coverage, or scope of the required insurance. Such notices shall contain a reference to each agreement number for which the insurance was obtained.
- (f) The Contractor and/or Subcontractor is hereby advised that copies of certificates of insurance may be subject to review and approval by the Department of General Services (DGS), Office of Risk and Insurance Management. The Contractor shall be notified by DHCS, in writing, if this provision is applicable to this Agreement. If DGS approval of the certificate of insurance is required, the Contractor agrees that no work or services shall be performed prior to obtaining said approval.
- (g) In the event the Contractor and/or Subcontractor fails to keep insurance coverage, as required herein, in effect at all times during vehicle possession, DHCS may, in addition to any other remedies it may have, terminate this Agreement upon the occurrence of such event.

5. Subcontract Requirements

(Applicable to agreements under which services are to be performed by subcontractors including independent consultants.)

- a. Prior written authorization will be required before the Contractor enters into or is reimbursed for any subcontract for services costing \$5,000 or more. Except as indicated in Paragraph a(3) herein, when securing subcontracts for services exceeding \$5,000, the Contractor shall obtain at least three bids or justify a sole source award.
- (1) The Contractor must provide in its request for authorization, all information necessary for evaluating the necessity or desirability of incurring such cost.
 - (2) DHCS may identify the information needed to fulfill this requirement.
 - (3) Subcontracts performed by the following entities or for the service types listed below are exempt from the bidding and sole source justification requirements:
 - (a) A local governmental entity or the federal government,
 - (b) A State college or State university from any State,
 - (c) A Joint Powers Authority,
 - (d) An auxiliary organization of a California State University or a California community college,
 - (e) A foundation organized to support the Board of Governors of the California Community Colleges,
 - (f) An auxiliary organization of the Student Aid Commission established under Education Code § 69522,
 - (g) Firms or individuals proposed for use and approved by DHCS' funding Program via acceptance of an application or proposal for funding or pre/post contract award negotiations,
 - (h) Entities and/or service types identified as exempt from advertising and competitive bidding in State Contracting Manual Chapter 5 Section 5.80 Subsection B.3. View this publication at the following Internet address: <http://www.dgs.ca.gov/ols/Resources/StateContractManual.aspx>.
- b. DHCS reserves the right to approve or disapprove the selection of subcontractors and with advance written notice, require the substitution of subcontractors and require the Contractor to terminate subcontracts entered into in support of this Agreement.

- (1) Upon receipt of a written notice from DHCS requiring the substitution and/or termination of a subcontract, the Contractor shall take steps to ensure the completion of any work in progress and select a replacement, if applicable, within 30 calendar days, unless a longer period is agreed to by DHCS.
- c. Actual subcontracts (i.e., written agreement between the Contractor and a subcontractor) of \$5,000 or more are subject to the prior review and written approval of DHCS. DHCS may, at its discretion, elect to waive this right. All such waivers shall be confirmed in writing by DHCS.
 - d. Contractor shall maintain a copy of each subcontract entered into in support of this Agreement and shall, upon request by DHCS, **CMS, OIG or Comptroller General**, make copies available for approval, inspection, or audit.
 - e. DHCS assumes no responsibility for the payment of subcontractors used in the performance of this Agreement. Contractor accepts sole responsibility for the payment of subcontractors used in the performance of this Agreement.
 - f. The Contractor is responsible for all performance requirements under this Agreement even though performance may be carried out through a subcontract.
 - g. The Contractor shall ensure that all subcontracts for services include provision(s) requiring compliance with applicable terms and conditions specified in this Agreement.
 - h. The Contractor agrees to include the following clause, relevant to record retention, in all subcontracts for services:

"(Subcontractor Name) agrees to maintain and preserve, until three years after termination of (Agreement Number) and final payment from DHCS to the Contractor, to permit DHCS or any duly authorized representative, to have access to, examine or audit any pertinent books, documents, papers and records related to this subcontract and to allow interviews of any employees who might reasonably have information related to such records."
 - i. Unless otherwise stipulated in writing by DHCS, the Contractor shall be the subcontractor's sole point of contact for all matters related to performance and payment under this Agreement.
 - j. **The delegated activities or obligations, and related reporting responsibilities, shall be specified in the contract or written agreement.**
 - k. **The subcontractor agrees to perform the delegated activities and reporting responsibilities as specified and in compliance with the Contractor's obligations.**
 - l. **The contract or written arrangement requires that if any of the Contractor's activities or obligations under its contract with the State are delegated to the subcontractor, then the contract or written arrangement between the Contractor and the subcontractor shall provide either for the revocation of the delegation of activities or obligations, or specify other remedies in instances where DHCS or the Contractor determine that the subcontractor has not performed satisfactorily.**
 - m. **The subcontractor shall agree to comply with all applicable Medicaid laws, regulations, including applicable sub-regulatory guidance and contract provisions.**
 - n. **DHCS, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under Contractor's contract with DHCS.**
 - o. **The contract between the Contractor and the subcontractor requires that the subcontractor shall make available, for purposes of an audit, evaluation, or inspection by DHCS, CMS, the DHHS Inspector General, the Comptroller General or their designees, of its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Denti-Cal Members.**

- p. The right to audit under section (n) shall exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.
- q. ~~g.~~ The contract between the Contractor and the subcontractor requires that If DHCS, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.
- j-r. Contractor shall, as applicable, advise all subcontractors of their obligations pursuant to the following numbered provisions of this Exhibit: 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, 12, 13, 14, 17, 19, 20, 24, 32 and/or other numbered provisions herein that are deemed applicable.

6. Income Restrictions

Unless otherwise stipulated in this Agreement, the Contractor agrees that any refunds, rebates, credits, or other amounts (including any interest thereon) accruing to or received by the Contractor under this Agreement shall be paid by the Contractor to DHCS, to the extent that they are properly allocable to costs for which the Contractor has been reimbursed by DHCS under this Agreement.

7. Audit and Record Retention

(Applicable to agreements in excess of \$10,000.)

- a. The Contractor and/or Subcontractor shall maintain books, records, documents, and other evidence, accounting procedures and practices, sufficient to properly reflect all direct and indirect costs of whatever nature claimed to have been incurred in the performance of this Agreement, including any matching costs and expenses. The foregoing constitutes "records" for the purpose of this provision.
- b. The Contractor's and/or subcontractor's facility or office or such part thereof as may be engaged in the performance of this Agreement and his/her records shall be subject at all reasonable times to inspection, audit, and reproduction by DHCS, CMS, OIG or Comptroller General.

DHCS, CMS, the HHS Inspector General, the Comptroller General, and their designees may, at any time, inspect and audit any records or documents of the Contractor, or its subcontractors, and may, at any time inspect the premises, physical facilities, and equipment that pertain to any aspect of services and activities performed, or determination of amounts payable under Contractor's contract with DHCS. This includes any records pertaining to the ability of the Contractor to bear the risk of financial losses, and the services performed or payable amounts under the contract.

- c. Contractor agrees that DHCS, the Department of General Services, the Bureau of State Audits, or their designated representatives including the Comptroller General of the United States shall have the right to review and to copy any records and supporting documentation pertaining to the performance of this Agreement. Contractor agrees to allow the auditor(s) access to such records during normal business hours and to allow interviews of any employees who might reasonably have information related to such records. Further, the Contractor agrees to include a similar right of the State to audit records and interview staff in any subcontract related to performance of this Agreement. (GC 8546.7, CCR Title 2, Section 1896).
- d. The Contractor and/or Subcontractor shall preserve and make available his/her records (1) for a period of three-ten (10) years from the date of final payment under this Agreement, and (2) for such longer period, if any, as is required by applicable statute, by any other provision of this Agreement, or by subparagraphs (1) or (2) below.
- (1) If this Agreement is completely or partially terminated, the records relating to the work terminated shall be preserved and made available for a period of three-ten (10) years from the date of any resulting final settlement.
- (2) If any litigation, claim, negotiation, audit, or other action involving the records has been started before the expiration of the three-ten -year period, the records shall be retained until completion of the action and resolution of all issues which arise from it, or until the end of the regular three-ten -year period, whichever is later.

- e. The Contractor and/or Subcontractor shall comply with the above requirements and be aware of the penalties for violations of fraud and for obstruction of investigation as set forth in Public Contract Code §

- f. The Contractor and/or Subcontractor may, at its discretion, following receipt of final payment under this Agreement, reduce its accounts, books and records related to this Agreement to microfilm, computer disk, CD ROM, DVD, or other data storage medium. Upon request by an authorized representative to inspect, audit or obtain copies of said records, the Contractor and/or Subcontractor must supply or make available applicable devices, hardware, and/or software necessary to view, copy and/or print said records. Applicable devices may include, but are not limited to, microfilm readers and microfilm printers, etc.
- g. The Contractor shall, if applicable, comply with the Single Audit Act and the audit reporting requirements set forth in OMB Circular A-133.

8. Site Inspection

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

9. Federal Contract Funds

(Applicable only to that portion of an agreement funded in part or whole with federal funds.)

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

10. Intellectual Property Rights

a. Ownership

- (1) Except where DHCS has agreed in a signed writing to accept a license, DHCS shall be and remain, without additional compensation, the sole owner of any and all rights, title and interest in all Intellectual Property, from the moment of creation, whether or not jointly conceived, that are made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement.
- (2) For the purposes of this Agreement, Intellectual Property means recognized protectable rights and interest such as: patents, (whether or not issued) copyrights, trademarks, service marks, applications for any of the foregoing, inventions, trade secrets, trade dress, logos, insignia, color combinations, slogans, moral rights, right of publicity, author's rights, contract and licensing rights, works, mask works, industrial design rights, rights of priority, know how, design flows, methodologies, devices, business processes, developments, innovations, good will and all other legal rights protecting intangible proprietary information as may exist now and/or here after come into existence, and all renewals and extensions, regardless of whether those rights arise under the laws of the United States, or any other state, country or jurisdiction.

- (a) For the purposes of the definition of Intellectual Property, "works" means all literary works, writings and printed matter including the medium by which they are recorded or reproduced, photographs, art work, pictorial and graphic representations and works of a similar nature, film, motion pictures, digital images, animation cells, and other audiovisual works including positives and negatives thereof, sound recordings, tapes, educational materials, interactive videos and any other materials or products created, produced, conceptualized and fixed in a tangible medium of expression. It includes preliminary and final products and any materials and information developed for the purposes of producing those final products. Works does not include articles submitted to peer review or reference journals or independent research projects.
- (3) In the performance of this Agreement, Contractor will exercise and utilize certain of its Intellectual Property in existence prior to the effective date of this Agreement. In addition, under this Agreement, Contractor may access and utilize certain of DHCS' Intellectual Property in existence prior to the effective date of this Agreement. Except as otherwise set forth herein, Contractor shall not use any of DHCS' Intellectual Property now existing or hereafter existing for any purposes without the prior written permission of DHCS. Except as otherwise set forth herein, neither the Contractor nor DHCS shall give any ownership interest in or rights to its Intellectual Property to the other Party. If during the term of this Agreement, Contractor accesses any third-party Intellectual Property that is licensed to DHCS, Contractor agrees to abide by all license and confidentiality restrictions applicable to DHCS in the third-party's license agreement.
- (4) Contractor agrees to cooperate with DHCS in establishing or maintaining DHCS' exclusive rights in the Intellectual Property, and in assuring DHCS' sole rights against third parties with respect to the Intellectual Property. If the Contractor enters into any agreements or subcontracts with other parties in order to perform this Agreement, Contractor shall require the terms of the Agreement(s) to include all Intellectual Property provisions. Such terms must include, but are not limited to, the subcontractor assigning and agreeing to assign to DHCS all rights, title and interest in Intellectual Property made, conceived, derived from, or reduced to practice by the subcontractor, Contractor or DHCS and which result directly or indirectly from this Agreement or any subcontract.
- (5) Contractor further agrees to assist and cooperate with DHCS in all reasonable respects, and execute all documents and, subject to reasonable availability, give testimony and take all further acts reasonably necessary to acquire, transfer, maintain, and enforce DHCS' Intellectual Property rights and interests.

b. Retained Rights / License Rights

- (1) Except for Intellectual Property made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement, Contractor shall retain title to all of its Intellectual Property to the extent such Intellectual Property is in existence prior to the effective date of this Agreement. Contractor hereby grants to DHCS, without additional compensation, a permanent, non-exclusive, royalty free, paid-up, worldwide, irrevocable, perpetual, non-terminable license to use, reproduce, manufacture, sell, offer to sell, import, export, modify, publicly and privately display/perform, distribute, and dispose Contractor's Intellectual Property with the right to sublicense through multiple layers, for any purpose whatsoever, to the extent it is incorporated in the Intellectual Property resulting from this Agreement, unless Contractor assigns all rights, title and interest in the Intellectual Property as set forth herein.
- (2) Nothing in this provision shall restrict, limit, or otherwise prevent Contractor from using any ideas, concepts, know-how, methodology or techniques related to its performance under this Agreement, provided that Contractor's use does not infringe the patent, copyright, trademark rights, license or other Intellectual Property rights of DHCS or third party, or result in a breach or default of any provisions of this Exhibit or result in a breach of any provisions of law relating to confidentiality.

c. Copyright

- (1) Contractor agrees that for purposes of copyright law, all works [as defined in Paragraph a, subparagraph (2)(a) of this provision] of authorship made by or on behalf of Contractor in connection with Contractor's performance of this Agreement shall be deemed "works made for hire". Contractor further agrees that the work of each person utilized by Contractor in connection with the performance of this Agreement will be a "work made for hire," whether that person is an employee of Contractor or that person has entered into an agreement with Contractor to perform the work. Contractor shall enter

into a written agreement with any such person that: (i) all work performed for Contractor shall be deemed a "work made for hire" under the Copyright Act and (ii) that person shall assign all right, title, and interest to DHCS to any work product made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement.

- (2) All materials, including, but not limited to, visual works or text, reproduced or distributed pursuant to this Agreement that include Intellectual Property made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement, shall include DHCS" notice of copyright, which shall read in 3mm or larger typeface: "© [Enter Current Year e.g., 2010, etc.], California Department of Health Care Services. This material may not be reproduced or disseminated without prior written permission from the California Department of Health Care Services." This notice should be placed prominently on the materials and set apart from other matter on the page where it appears. Audio productions shall contain a similar audio notice of copyright.

d. Patent Rights

With respect to inventions made by Contractor in the performance of this Agreement, which did not result from research and development specifically included in the Agreement's scope of work, Contractor hereby grants to DHCS a license as described under Section b of this provision for devices or material incorporating, or made through the use of such inventions. If such inventions result from research and development work specifically included within the Agreement's scope of work, then Contractor agrees to assign to DHCS, without additional compensation, all its right, title and interest in and to such inventions and to assist DHCS in securing United States and foreign patents with respect thereto.

e. Third-Party Intellectual Property

Except as provided herein, Contractor agrees that its performance of this Agreement shall not be dependent upon or include any Intellectual Property of Contractor or third party without first: (i) obtaining DHCS" prior written approval; and (ii) granting to or obtaining for DHCS, without additional compensation, a license, as described in Section b of this provision, for any of Contractor's or third-party's Intellectual Property in existence prior to the effective date of this Agreement. If such a license upon the these terms is unattainable, and DHCS determines that the Intellectual Property should be included in or is required for Contractor's performance of this Agreement, Contractor shall obtain a license under terms acceptable to DHCS.

f. Warranties

- (1) Contractor represents and warrants that:

- (a) It is free to enter into and fully perform this Agreement.
- (b) It has secured and will secure all rights and licenses necessary for its performance of this Agreement.
- (c) Neither Contractor's performance of this Agreement, nor the exercise by either Party of the rights granted in this Agreement, nor any use, reproduction, manufacture, sale, offer to sell, import, export, modification, public and private display/performance, distribution, and disposition of the Intellectual Property made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement will infringe upon or violate any Intellectual Property right, non-disclosure obligation, or other proprietary right or interest of any third-party or entity now existing under the laws of, or hereafter existing or issued by, any state, the United States, or any foreign country. There is currently no actual or threatened claim by any such third party based on an alleged violation of any such right by Contractor.
- (d) Neither Contractor's performance nor any part of its performance will violate the right of privacy of, or constitute a libel or slander against any person or entity.

- (e) It has secured and will secure all rights and licenses necessary for Intellectual Property including, but not limited to, consents, waivers or releases from all authors of music or performances used, and talent (radio, television and motion picture talent), owners of any interest in and to real estate, sites, locations, property or props that may be used or shown.
 - (f) It has not granted and shall not grant to any person or entity any right that would or might derogate, encumber, or interfere with any of the rights granted to DHCS in this Agreement.
 - (g) It has appropriate systems and controls in place to ensure that state funds will not be used in the performance of this Agreement for the acquisition, operation or maintenance of computer software in violation of copyright laws.
 - (h) It has no knowledge of any outstanding claims, licenses or other charges, liens, or encumbrances of any kind or nature whatsoever that could affect in any way Contractor's performance of this Agreement.
- (2) DHCS MAKES NO WARRANTY THAT THE INTELLECTUAL PROPERTY RESULTING FROM THIS AGREEMENT DOES NOT INFRINGE UPON ANY PATENT, TRADEMARK, COPYRIGHT OR THE LIKE, NOW EXISTING OR SUBSEQUENTLY ISSUED.

g. Intellectual Property Indemnity

- (1) Contractor shall indemnify, defend and hold harmless DHCS and its licensees and assignees, and its officers, directors, employees, agents, representatives, successors, and users of its products, ("Indemnitees") from and against all claims, actions, damages, losses, liabilities (or actions or proceedings with respect to any thereof), whether or not rightful, arising from any and all actions or claims by any third party or expenses related thereto (including, but not limited to, all legal expenses, court costs, and attorney's fees incurred in investigating, preparing, serving as a witness in, or defending against, any such claim, action, or proceeding, commenced or threatened) to which any of the Indemnitees may be subject, whether or not Contractor is a party to any pending or threatened litigation, which arise out of or are related to (i) the incorrectness or breach of any of the representations, warranties, covenants or agreements of Contractor pertaining to Intellectual Property; or (ii) any Intellectual Property infringement, or any other type of actual or alleged infringement claim, arising out of DHCS' use, reproduction, manufacture, sale, offer to sell, distribution, import, export, modification, public and private performance/display, license, and disposition of the Intellectual Property made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement. This indemnity obligation shall apply irrespective of whether the infringement claim is based on a patent, trademark or copyright registration that issued after the effective date of this Agreement. DHCS reserves the right to participate in and/or control, at Contractor's expense, any such infringement action brought against DHCS.
- (2) Should any Intellectual Property licensed by the Contractor to DHCS under this Agreement become the subject of an Intellectual Property infringement claim, Contractor will exercise its authority reasonably and in good faith to preserve DHCS' right to use the licensed Intellectual Property in accordance with this Agreement at no expense to DHCS. DHCS shall have the right to monitor and appear through its own counsel (at Contractor's expense) in any such claim or action. In the defense or settlement of the claim, Contractor may obtain the right for DHCS to continue using the licensed Intellectual Property; or, replace or modify the licensed Intellectual Property so that the replaced or modified Intellectual Property becomes non-infringing provided that such replacement or modification is functionally equivalent to the original licensed Intellectual Property. If such remedies are not reasonably available, DHCS shall be entitled to a refund of all monies paid under this Agreement, without restriction or limitation of any other rights and remedies available at law or in equity.

- (3) Contractor agrees that damages alone would be inadequate to compensate DHCS for breach of any term of this Intellectual Property Exhibit by Contractor. Contractor acknowledges DHCS would suffer irreparable harm in the event of such breach and agrees DHCS shall be entitled to obtain equitable relief, including without limitation an injunction, from a court of competent jurisdiction, without restriction or limitation of any other rights and remedies available at law or in equity.

h. Federal Funding

In any agreement funded in whole or in part by the federal government, DHCS may acquire and maintain the Intellectual Property rights, title, and ownership, which results directly or indirectly from the Agreement; except as provided in 37 Code of Federal Regulations part 401.14; however, the federal government shall have a non-exclusive, nontransferable, irrevocable, paid-up license throughout the world to use, duplicate, or dispose of such Intellectual Property throughout the world in any manner for governmental purposes and to have and permit others to do so.

i. Survival

The provisions set forth herein shall survive any termination or expiration of this Agreement or any project schedule.

11. Air or Water Pollution Requirements

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

- a. Government contractors agree to comply with all applicable standards, orders, or requirements issued under section 306 of the Clean Air Act [42 U.S.C. 1857(h)], section 508 of the Clean Water Act (33 U.S.C. 1368), Executive Order 11738, and Environmental Protection Agency regulations (40 CFR part 15).
- b. Institutions of higher education, hospitals, nonprofit organizations and commercial businesses agree to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 U.S.C. 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 U.S.C. 1251 et seq.), as amended.

12. Prior Approval of Training Seminars, Workshops or Conferences

Contractor shall obtain prior DHCS approval of the location, costs, dates, agenda, instructors, instructional materials, and attendees at any reimbursable training seminar, workshop, or conference conducted pursuant to this Agreement and of any reimbursable publicity or educational materials to be made available for distribution. The Contractor shall acknowledge the support of the State whenever publicizing the work under this Agreement in any media. This provision does not apply to necessary staff meetings or training sessions held for the staff of the Contractor or Subcontractor to conduct routine business matters.

13. Confidentiality of Information

- a. The Contractor and its employees, agents, or subcontractors shall protect from unauthorized disclosure names and other identifying information concerning persons either receiving services pursuant to this Agreement or persons whose names or identifying information become available or are disclosed to the Contractor, its employees, agents, or subcontractors as a result of services performed under this Agreement, except for statistical information not identifying any such person.
- b. The Contractor and its employees, agents, or subcontractors shall not use such identifying information for any purpose other than carrying out the Contractor's obligations under this Agreement.
- c. The Contractor and its employees, agents, or subcontractors shall promptly transmit to the DHCS Program Contract Manager all requests for disclosure of such identifying information not emanating from the client or person.

- d. The Contractor shall not disclose, except as otherwise specifically permitted by this Agreement or authorized by the client, any such identifying information to anyone other than DHCS without prior written authorization from the DHCS Program Contract Manager, except if disclosure is required by State or Federal law.
- e. For purposes of this provision, identity shall include, but not be limited to name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.
- f. As deemed applicable by DHCS, this provision may be supplemented by additional terms and conditions covering personal health information (PHI) or personal, sensitive, and/or confidential information (PSCI). Said terms and conditions will be outlined in one or more exhibits that will either be attached to this Agreement or incorporated into this Agreement by reference.

14. Documents, Publications and Written Reports

(Applicable to agreements over \$5,000 under which publications, written reports and documents are developed or produced. Government Code Section 7550.)

Any document, publication or written report (excluding progress reports, financial reports and normal contractual communications) prepared as a requirement of this Agreement shall contain, in a separate section preceding the main body of the document, the number and dollar amounts of all contracts or agreements and subcontracts relating to the preparation of such document or report, if the total cost for work by nonemployees of the State exceeds \$5,000.

15. Dispute Resolution Process

- a. A Contractor grievance exists whenever there is a dispute arising from DHCS' action in the administration of an agreement. If there is a dispute or grievance between the Contractor and DHCS, the Contractor must seek resolution using the procedure outlined below.
 - (1) The Contractor should first informally discuss the problem with the DHCS Program Contract Manager. If the problem cannot be resolved informally, the Contractor shall direct its grievance together with any evidence, in writing, to the program Branch Chief. The grievance shall state the issues in dispute, the legal authority or other basis for the Contractor's position and the remedy sought. The Branch Chief shall render a decision within ten (10) working days after receipt of the written grievance from the Contractor. The Branch Chief shall respond in writing to the Contractor indicating the decision and reasons therefore. If the Contractor disagrees with the Branch Chief's decision, the Contractor may appeal to the second level.
 - (2) When appealing to the second level, the Contractor must prepare an appeal indicating the reasons for disagreement with Branch Chief's decision. The Contractor shall include with the appeal a copy of the Contractor's original statement of dispute along with any supporting evidence and a copy of the Branch Chief's decision. The appeal shall be addressed to the Deputy Director of the division in which the branch is organized within ten (10) working days from receipt of the Branch Chief's decision. The Deputy Director of the division in which the branch is organized or his/her designee shall meet with the Contractor to review the issues raised. A written decision signed by the Deputy Director of the division in which the branch is organized or his/her designee shall be directed to the Contractor within twenty (20) working days of receipt of the Contractor's second level appeal.
- b. If the Contractor wishes to appeal the decision of the Deputy Director of the division in which the branch is organized or his/her designee, the Contractor shall follow the procedures set forth in Health and Safety Code Section 100171.
 - (1)

- c. Unless otherwise stipulated in writing by DHCS, all dispute, grievance and/or appeal correspondence shall be directed to the DHCS Program Contract Manager.
- d. There are organizational differences within DHCS' funding programs and the management levels identified in this dispute resolution provision may not apply in every contractual situation. When a grievance is received and organizational differences exist, the Contractor shall be notified in writing by the DHCS Program Contract Manager of the level, name, and/or title of the appropriate management official that is responsible for issuing a decision at a given level.

16. Financial and Compliance Audit Requirements

- a. The definitions used in this provision are contained in Section 38040 of the Health and Safety Code, which by this reference is made a part hereof.
- b. Direct service contract means a contract or agreement for services contained in local assistance or subvention programs or both (see Health and Safety [H&S] Code Section 38020). Direct service contracts shall not include contracts, agreements, grants, or subventions to other governmental agencies or units of government nor contracts or agreements with regional centers or area agencies on aging (H&S Code Section 38030).
- c. The Contractor, as indicated below, agrees to obtain one of the following audits:
 - (1) If the Contractor is a nonprofit organization (as defined in H&S Code Section 38040) and receives \$25,000 or more from any State agency under a direct service contract or agreement; the Contractor agrees to obtain an annual single, organization wide, financial and compliance audit. Said audit shall be conducted according to Generally Accepted Auditing Standards. This audit does not fulfill the audit requirements of Paragraph c(3) below. The audit shall be completed by the 15th day of the fifth month following the end of the Contractor's fiscal year, and/or
 - (2) If the Contractor is a nonprofit organization (as defined in H&S Code Section 38040) and receives less than \$25,000 per year from any State agency under a direct service contract or agreement, the Contractor agrees to obtain a biennial single, organization wide financial and compliance audit, unless there is evidence of fraud or other violation of state law in connection with this Agreement. This audit does not fulfill the audit requirements of Paragraph c(3) below. The audit shall be completed by the 15th day of the fifth month following the end of the Contractor's fiscal year, and/or
 - (3) If the Contractor is a State or Local Government entity or Nonprofit organization (as defined by the Federal Office of Management and Budget [OMB] Circular A-133) and expends \$500,000 or more in Federal awards, the Contractor agrees to obtain an annual single, organization wide, financial and compliance audit according to the requirements specified in OMB Circular A-133 entitled "Audits of States, Local Governments, and Non-Profit Organizations". An audit conducted pursuant to this provision will fulfill the audit requirements outlined in Paragraphs c(1) and c(2) above. The audit shall be completed by the end of the ninth month following the end of the audit period. The requirements of this provision apply if:
 - (a) The Contractor is a recipient expending Federal awards received directly from Federal awarding agencies, or
 - (b) The Contractor is a subrecipient expending Federal awards received from a pass-through entity such as the State, County or community based organization.

- (4) If the Contractor submits to DHCS a report of an audit other than an OMB A-133 audit, the Contractor must also submit a certification indicating the Contractor has not expended \$500,000 or more in federal funds for the year covered by the audit report.
- d. Two copies of the audit report shall be delivered to the DHCS program funding this Agreement. The audit report must identify the Contractor's legal name and the number assigned to this Agreement. The audit report shall be due within 30 days after the completion of the audit. Upon receipt of said audit report, the DHCS Program Contract Manager shall forward the audit report to DHCS' Audits and Investigations Unit if the audit report was submitted under Section 16.c(3), unless the audit report is from a City, County, or Special District within the State of California whereby the report will be retained by the funding program.
 - e. The cost of the audits described herein may be included in the funding for this Agreement up to the proportionate amount this Agreement represents of the Contractor's total revenue. The DHCS program funding this Agreement must provide advance written approval of the specific amount allowed for said audit expenses.
 - f. The State or its authorized designee, including the Bureau of State Audits, is responsible for conducting agreement performance audits which are not financial and compliance audits. Performance audits are defined by Generally Accepted Government Auditing Standards.
 - g. Nothing in this Agreement limits the State's responsibility or authority to enforce State law or regulations, procedures, or reporting requirements arising thereto.
 - h. Nothing in this provision limits the authority of the State to make audits of this Agreement, provided however, that if independent audits arranged for by the Contractor meet Generally Accepted Governmental Auditing Standards, the State shall rely on those audits and any additional audit work and shall build upon the work already done.
 - i. The State may, at its option, direct its own auditors to perform either of the audits described above. The Contractor will be given advance written notification, if the State chooses to exercise its option to perform said audits.
 - j. The Contractor shall include a clause in any agreement the Contractor enters into with the audit firm doing the single organization wide audit to provide access by the State or Federal Government to the working papers of the independent auditor who prepares the single organization wide audit for the Contractor.
 - k. Federal or state auditors shall have "expanded scope auditing" authority to conduct specific program audits during the same period in which a single organization wide audit is being performed, but the audit report has not been issued. The federal or state auditors shall review and have access to the current audit work being conducted and will not apply any testing or review procedures which have not been satisfied by previous audit work that has been completed.

The term "expanded scope auditing" is applied and defined in the U.S. General Accounting Office (GAO) issued Standards for *Audit of Government Organizations, Programs, Activities and Functions*, better known as the "yellow book".

17. Human Subjects Use Requirements

(Applicable only to federally funded agreements/grants in which performance, directly or through a subcontract/subaward, includes any tests or examination of materials derived from the human body.)

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

18. Novation Requirements

If the Contractor proposes any novation agreement, DHCS shall act upon the proposal within 60 days after receipt of the written proposal. DHCS may review and consider the proposal, consult and negotiate with the Contractor, and accept or reject all or part of the proposal. Acceptance or rejection of the proposal may be made orally within the 60-day period and confirmed in writing within five days of said decision. Upon written acceptance of the proposal, DHCS will initiate an amendment to this Agreement to formally implement the approved proposal.

19. Debarment and Suspension Certification

(Applicable to all agreements funded in part or whole with federal funds.)

- a. By signing this Agreement, the Contractor/Grantee agrees to comply with applicable federal suspension and debarment regulations including, but not limited to 7 CFR Part 3017, 45 CFR 76, 40 CFR 32 or 34 CFR 85.
- b. By signing this Agreement, the Contractor certifies to the best of its knowledge and belief, that it and its principals:
 - (1) Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency;
 - (2) Have not within a three-year period preceding this application/proposal/agreement been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
 - (3) Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in Paragraph b(2) herein; and
 - (4) Have not within a three-year period preceding this application/proposal/agreement had one or more public transactions (Federal, State or local) terminated for cause or default.
 - (5) Shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under federal regulations (i.e., 48 CFR part 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State.
 - (6) Will include a clause entitled, "Debarment and Suspension Certification" that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.
- c. If the Contractor is unable to certify to any of the statements in this certification, the Contractor shall submit an explanation to the DHCS Program ContractManager.
- d. The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.
- e. If the Contractor knowingly violates this certification, in addition to other remedies available to the Federal Government, the DHCS may terminate this Agreement for cause or default.

20. Smoke-Free Workplace Certification

(Applicable to federally funded agreements/grants and subcontracts/subawards, that provide health, day care, early childhood development services, education or library services to children under 18 directly or through local governments.)

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

21. Covenant Against Contingent Fees

(Applicable only to federally funded agreements.)

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

22. Payment Withholds

(Applicable only if a final report is required by this Agreement. Not applicable to government entities.)

Unless waived or otherwise stipulated in this Agreement, DHCS may, at its discretion, withhold 10 percent (10%) of the face amount of the Agreement, 50 percent (50%) of the final invoice, or \$3,000 whichever is greater, until DHCS receives a final report that meets the terms, conditions and/or scope of work requirements of this Agreement.

23. Performance Evaluation

(Not applicable to grant agreements.)

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

24. Officials Not to Benefit

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

25. Four-Digit Date Compliance

(Applicable to agreements in which Information Technology (IT) services are provided to DHCS or if IT equipment is procured.)

Contractor warrants that it will provide only Four-Digit Date Compliant (as defined below) Deliverables and/or services to the State. "Four Digit Date compliant" Deliverables and services can accurately process, calculate, compare, and sequence date data, including without limitation date data arising out of or relating to leap years and changes in centuries. This warranty and representation is subject to the warranty terms and conditions of this Contract and does not limit the generality of warranty obligations set forth elsewhere herein.

26. Prohibited Use of State Funds for Software

(Applicable to agreements in which computer software is used in performance of the work.)

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

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

(Applicable to that portion of an agreement that is federally funded and entered into with institutions of higher education, hospitals, nonprofit organizations or commercial businesses.)

Positive efforts shall be made to use small businesses, minority-owned firms and women's business enterprises, whenever possible (i.e., procurement of goods and/or services). Contractors shall take all of the following steps to further this goal.

- (1) Ensure that small businesses, minority-owned firms, and women's business enterprises are used to the fullest extent practicable.
- (2) Make information on forthcoming purchasing and contracting opportunities available and arrange time frames for purchases and contracts to encourage and facilitate participation by small businesses, minority-owned firms, and women's business enterprises.
- (3) Consider in the contract process whether firms competing for larger contracts intend to subcontract with small businesses, minority-owned firms, and women's business enterprises.
- (4) Encourage contracting with consortiums of small businesses, minority-owned firms and women's business enterprises when a contract is too large for one of these firms to handle individually.
- (5) Use the services and assistance, as appropriate, of such organizations as the Federal Small Business Administration and the U.S. Department of Commerce's Minority Business Development Agency in the solicitation and utilization of small businesses, minority-owned firms and women's business enterprises.

28. Alien Ineligibility Certification

(Applicable to sole proprietors entering federally funded agreements.)

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

29. Union Organizing

(Applicable only to grant agreements.)

Grantee, by signing this Agreement, hereby acknowledges the applicability of Government Code Sections 16645 through 16649 to this Agreement. Furthermore, Grantee, by signing this Agreement, hereby certifies that:

- a. No state funds disbursed by this grant will be used to assist, promote or deter union organizing.
- b. Grantee shall account for state funds disbursed for a specific expenditure by this grant, to show those funds were allocated to that expenditure.
- c. Grantee shall, where state funds are not designated as described in b herein, allocate, on a pro-rata basis, all disbursements that support the grant program.
- d. If Grantee makes expenditures to assist, promote or deter union organizing, Grantee will maintain records sufficient to show that no state funds were used for those expenditures, and that Grantee shall provide those records to the Attorney General upon request.

30. Contract Uniformity (Fringe Benefit Allowability)

(Applicable only to nonprofit organizations.)

Pursuant to the provisions of Article 7 (commencing with Section 100525) of Chapter 3 of Part 1 of Division 101 of the Health and Safety Code, DHCS sets forth the following policies, procedures, and guidelines regarding the reimbursement of fringe benefits.

- a. As used herein fringe benefits shall mean an employment benefit given by one's employer to an employee in addition to one's regular or normal wages or salary.
- b. As used herein, fringe benefits do not include:
 - (1) Compensation for personal services paid currently or accrued by the Contractor for services of employees rendered during the term of this Agreement, which is identified as regular or normal salaries and wages, annual leave, vacation, sick leave, holidays, jury duty and/or military leave/training.
 - (2) Director's and executive committee member's fees.
 - (3) Incentive awards and/or bonus incentive pay.
 - (4) Allowances for off-site pay.
 - (5) Location allowances.
 - (6) Hardship pay.
 - (7) Cost-of-living differentials
- c. Specific allowable fringe benefits include:
 - (1) Fringe benefits in the form of employer contributions for the employer's portion of payroll taxes (i.e., FICA, SUI, SDI), employee health plans (i.e., health, dental and vision), unemployment insurance, worker's compensation insurance, and the employer's share of pension/retirement plans, provided they are granted in accordance with established written organization policies and meet all legal and Internal Revenue Service requirements.
- d. To be an allowable fringe benefit, the cost must meet the following criteria:
 - (1) Be necessary and reasonable for the performance of the Agreement.
 - (2) Be determined in accordance with generally accepted accounting principles.
 - (3) Be consistent with policies that apply uniformly to all activities of the Contractor.
- e. Contractor agrees that all fringe benefits shall be at actual cost.

f. Earned/Accrued Compensation

- (1) Compensation for vacation, sick leave and holidays is limited to that amount earned/accrued within the agreement term. Unused vacation, sick leave and holidays earned from periods prior to the agreement term cannot be claimed as allowable costs. See Provision f (3)(a) for an example.
- (2) For multiple year agreements, vacation and sick leave compensation, which is earned/accrued but not paid, due to employee(s) not taking time off may be carried over and claimed within the overall term of the multiple years of the Agreement. Holidays cannot be carried over from one agreement year to the next. See Provision f (3)(b) for an example.
- (3) For single year agreements, vacation, sick leave and holiday compensation that is earned/accrued but not paid, due to employee(s) not taking time off within the term of the Agreement, cannot be claimed as an allowable cost. See Provision f (3)(c) for an example.

(a) Example No. 1:

If an employee, John Doe, earns/accrues three weeks of vacation and twelve days of sick leave each year, then that is the maximum amount that may be claimed during a one year agreement. If John Doe has five weeks of vacation and eighteen days of sick leave at the beginning of an agreement, the Contractor during a one-year budget period may only claim up to three weeks of vacation and twelve days of sick leave as actually used by the employee. Amounts earned/accrued in periods prior to the beginning of the Agreement are not an allowable cost.

(b) Example No. 2:

If during a three-year (multiple year) agreement, John Doe does not use his three weeks of vacation in year one, or his three weeks in year two, but he does actually use nine weeks in year three; the Contractor would be allowed to claim all nine weeks paid for in year three. The total compensation over the three-year period cannot exceed 156 weeks (3 x 52 weeks).

(c) Example No. 3:

If during a single year agreement, John Doe works fifty weeks and used one week of vacation and one week of sick leave and all fifty-two weeks have been billed to DHCS, the remaining unused two weeks of vacation and seven days of sick leave may not be claimed as an allowable cost.

31. Suspension or Stop Work Notification

- a. DHCS may, at any time, issue a notice to suspend performance or stop work under this Agreement. The initial notification may be a verbal or written directive issued by the funding Program's Contract Manager. Upon receipt of said notice, the Contractor is to suspend and/or stop all, or any part, of the work called for by this Agreement.
- b. Written confirmation of the suspension or stop work notification with directions as to what work (if not all) is to be suspended and how to proceed will be provided within 30 working days of the verbal notification. The suspension or stop work notification shall remain in effect until further written notice is received from DHCS. The resumption of work (in whole or part) will be at DHCS' discretion and upon receipt of written confirmation.
 - (1) Upon receipt of a suspension or stop work notification, the Contractor shall immediately comply with its terms and take all reasonable steps to minimize or halt the incurrence of costs allocable to the performance covered by the notification during the period of work suspension or stoppage.
 - (2) Within 90 days of the issuance of a suspension or stop work notification, DHCS shall either:
 - (a) Cancel, extend, or modify the suspension or stop work notification; or
 - (b) Terminate the Agreement as provided for in the Cancellation / Termination clause of the Agreement.

- c. If a suspension or stop work notification issued under this clause is canceled or the period of suspension or any extension thereof is modified or expires, the Contractor may resume work only upon written concurrence of funding Program's Contract Manager.
- d. If the suspension or stop work notification is cancelled and the Agreement resumes, changes to the services, deliverables, performance dates, and/or contract terms resulting from the suspension or stop work notification shall require an amendment to the Agreement.
- e. If a suspension or stop work notification is not canceled and the Agreement is cancelled or terminated pursuant to the provision entitled Cancellation / Termination, DHCS shall allow reasonable costs resulting from the suspension or stop work notification in arriving at the settlement costs.
- f. DHCS shall not be liable to the Contractor for loss of profits because of any suspension or stop work notification issued under this clause.

32. Lobbying Restrictions and Disclosure Certification

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

a. Certification and Disclosure Requirements

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

b. Prohibition

Section 1352 of Title 31, U.S.C., provides in part that no appropriated funds may be expended by the recipient of a federal contract or agreement, grant, loan, or cooperative agreement to pay any person for

Attachment 1

influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract or agreement, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract or agreement, grant, loan, or cooperative agreement.

Attachment 1

State of California
Department of Health Care Services

CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this Federal contract, Federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this Federal contract, grant, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, "Disclosure of Lobbying Activities" in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of \$100,000 or more, and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

Name of Contractor

Printed Name of Person Signing for Contractor

Contract / Grant Number

Signature of Person Signing for Contractor

Date

Title

After execution by or on behalf of Contractor, please return to:

California Department of Health Care Services

DHCS reserves the right to notify the contractor in writing of an alternate submission address.

Attachment 2

CERTIFICATION REGARDING LOBBYING

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

Approved by OMB
0348-0046

1. Type of Federal Action: [] a. contract b. grant c. cooperative agreement d. loan e. loan guarantee f. loan insurance	2. Status of Federal Action: [] a. bid/offer/application b. initial award c. post-award	3. Report Type: [] a. initial filing b. material change For Material Change Only: Year _____ quarter _____ date of last report _____.
4. Name and Address of Reporting Entity: <input type="checkbox"/> Prime <input type="checkbox"/> Subawardee Tier____, if known: Congressional District, If known:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, If known:	
6. Federal Department/Agency	7. Federal Program Name/Description: CDFA Number, if applicable: _____	
8. Federal Action Number, if known:	9. Award Amount, if known: \$	
10.a. Name and Address of Lobbying Registrant <i>(If individual, last name, first name, MI):</i>	b. Individuals Performing Services <i>(including address if different from 10a. (Last name, First name, MI):</i>	
11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be available for public inspection. Any person that fails to file the required disclosure shall be subject to a not more than \$100,000 for each such failure.	Signature: _____ Print Name: _____ Title: _____ Telephone No.: _____ Date: _____	
Federal Use Only		Authorized for Local Reproduction Standard Form-LLL (Rev. 7-97)

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.
2. Identify the status of the covered Federal action.
3. Identify the appropriate classification of this report. If this is a followup report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.
4. Enter the full name, address, city, State and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.
5. If the organization filing the report in item 4 checks "Subawardee," then enter the full name, address, city, State and zip code of the prime Federal recipient. Include Congressional District, if known.
6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.
7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.
8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency). Include prefixes, e.g., "RFP-DE-90-001".
9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.
10. (a) Enter the full name, address, city, State and zip code of the lobbying registrant under the Lobbying Disclosure Act of 1995 engaged by the reporting entity identified in item 4 to influence the covered Federal action.

(b) Enter the full names of the individual(s) performing services, and include full address if different from 10 (a). Enter Last Name, First Name, and Middle Initial (MI).
11. The certifying official shall sign and date the form, print his/her name, title, and telephone number.

According to the Paperwork Reduction Act, as amended, no persons are required to respond to a collection of information unless it displays a valid OMB Control Number. The valid OMB control number for this information collection is OMB No. 0348-0046. Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0046), Washington, DC 20503.

**Exhibit E
Additional Provisions****1. Additional Incorporated Exhibits**

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

- 1) Exhibit G HIPAA Business Associate Addendum
- 2) Narrative Proposal Submitted by the Contractor.

In the event of a conflict between the provisions of Exhibit E and any other part of this contract, the provisions of Exhibit E shall prevail.

2. Amendment Process

In addition to Exhibit C, Provision 2, Amendment, Contractor also agrees to the following:

Should either party, during the term of this Agreement, desire a change or amendment to the terms of this Agreement, such changes or amendments shall be proposed in writing to the other party, who will respond in writing as to whether the proposed changes/amendments are accepted or rejected. If accepted and after negotiations are concluded, the agreed upon changes shall be made through the State's official agreement amendment process, unless otherwise stipulated within this Agreement. No amendment will be considered binding on either party until it is formally approved by both parties and the Department of General Services (DGS), if DGS approval is required.

3. Termination

- a. Termination without Cause – State

DHCS may terminate performance of work under this contract in whole, or in part whenever for any reason DHCS determines that the termination is in the best interest of the State. Notification shall be given at least six (6) months prior to the effective date of termination.

- b. Termination with Cause – State

- 1) DHCS shall terminate this contract pursuant to the provisions of Welfare and Institutions Code Section 14304(a) and 22 CCR 53352.
- 2) 42 CFR § 438.708 provides that DHCS may terminate a contract and enroll that Contractor's Members in other DMC plans or provide their benefits through other options included in DHCS' plan if DHCS determines that the Contractor has failed to carry out substantive terms of the contract, or meet applicable requirements in sections 1932, 1903(m), and 1905(t) of the Social Security Act.
- 3) 42 CFR § 438.710 requires that DHCS must provide the Contractor a pre-termination hearing before terminating the contract under 42 CFR § 438.708.
- 4) DHCS shall terminate this contract in the event that: (1) DHHS determines that the Contractor does not meet the requirements for participation in the Medicaid program, Title

XIX of the Social Security Act (42 USC 1396 et. seq.), or (2) the Department of Managed Health Care finds that the Contractor no longer qualifies for licensure under the Knox-Keene Health Care Service Plan Act (Health and Safety Code § 1340 et seq.) by giving written notice to the Contractor.

- 5) In cases where DHCS determines the health and welfare of Members is jeopardized by continuation of the contract, the contract will be immediately terminated. Notification will state the effective date of and the reason for the termination.
- 6) DHCS shall terminate the contract for Contractor's non-compliance with CAP recommendations agreed upon by the Contractor and DHCS.

c. Termination without Cause – Contractor

- 1) Contractor may terminate this contract without cause by giving written notice of termination to DHCS at least six (6) months prior to the effective date of the termination.
- 2) Contractor may terminate this contract if a change in contractual obligations is created by a State or Federal change in the Medi-Cal program, or a lawsuit, that substantially alters the financial assumptions and conditions under which the Contractor entered into this contract, such that Contractor can demonstrate to the satisfaction of DHCS that it cannot remain financially solvent through the term of the contract. Such termination shall not take effect more than six (6) months after DHCS has made its determination that Contractor cannot remain financially solvent through the term of the contract.

At the same time and along with Contractor's written notice of termination, Contractor shall submit a complete detailed written financial analysis to DHCS supporting its conclusions that it cannot remain financially solvent. At the request of DHCS, Contractor shall submit or otherwise make conveniently and timely available to DHCS, all of Contractor's financial work papers, financial reports, financial books and other records, bank statements, computer records, and any other information required by DHCS to evaluate Contractor's financial analysis. Failure by Contractor to provide a complete and detailed financial analysis with Contractor's termination notice or Contractor's failure to timely provide any additional requested financial information may extend Contractor's requested date of termination. Termination by Contractor pursuant to this Provision shall not relieve Contractor from performing the Phaseout Requirements set forth in Provision 17.

d. Termination of Obligations

All obligations to provide covered services under this contract or contract extension will automatically terminate on the date the Operations Period ends. Termination under this section does not relieve Contractor of its contract termination obligations under Provision 17, Phaseout Requirements, which shall be performed after contract termination.

e. Notice to Members of Transfer of Care

At least sixty (60) calendar days prior to the termination of the contract, DHCS will notify Members about their dental benefits and available options.

f. Prohibited Contracts due to Termination

Any contractor terminated by the State during the life of the contract shall be prohibited from participating in the next dental Request for Application (RFA) or dental Request for Proposal (RFP) procurement.

g. **Notice of ~~Sanctions and~~ Pre-Termination Hearing**

~~Except as provided in 42 CFR §438.706(c), 42 CFR § 438.710 provides that before imposing any of the intermediate sanctions specified, the State must give the affected entity timely written notice that explains the basis and nature of the action and any other appeal rights the state has elected to provide, and must provide the entity a pre-termination hearing.~~

The State must:

- 1. Provide the contractor written notification of its intent to terminate, the reason for termination, and the time and place of the hearing;**
- 2. After the hearing, give the contractor written notice of the decision either affirming or reversing the proposed termination of the contract and, for an affirming decision, the effective date of termination; and**
- 3. For an affirming decision, DHCS shall provide contractor's members notice of the termination and information, consistent with 42 CFR § 438.10, on members' options for receiving Medicaid services following the effective date of termination.**

~~After notifying the Contractor of DHCS' intent to terminate the contract, DHCS may give the Contractor's Members written notice of DHCS' intent to terminate, and to allow Members to disenroll immediately without cause.~~

h. **Special Rules for Temporary Management**

The State may impose temporary management if it finds there is:

- 1. Continued egregious behavior by the contractor, including, but not limited to, behavior that is described in 42 CFR § 438.700, or that is contrary to any requirements of sections 1903(m) and 1932 of the Social Security Act,**
- 2. There is a substantial risk to members' health, or**
- 3. If it is necessary to ensure the health of members.**

i. **Required Imposition of Sanction**

The State may impose temporary management (regardless of any other sanction that may be imposed) if it finds that the Contractor has repeatedly failed to meet substantive requirements in sections 1903(m) or 1932 of the Act.

The State may not delay imposition to provide a hearing or terminate temporary management until the Contractor can ensure that the sanctioned behavior will not recur.

4. Dispute Resolution Process

This Disputes section will be used by the Contractor as the means of seeking resolution of disputes on contractual issues.

Filing a dispute will not preclude DHCS from recouping the value of the amount in dispute from the Contractor or from offsetting this amount from subsequent capitation payment(s). If the amount to be recouped exceeds 25 percent of the capitation payment, amounts of up to 25 percent will be withheld from successive capitation payments until the amount in dispute is fully recouped.

a. Disputes Resolution by Negotiation

DHCS and Contractor agree to try to resolve all contractual issues by negotiation and mutual agreement at the Contracting Officer level without litigation. The parties recognize that the implementation of this policy depends on open-mindedness, and the need for both sides to present adequate supporting information on matters in question.

b. Notification of Dispute

Within fifteen (15) calendar days of the date the dispute concerning performance of this contract arises or otherwise becomes known to the Contractor, the Contractor will notify the Contracting Officer in writing of the dispute, describing the conduct (including actions, inactions, and written or oral communications) which it is disputing.

The Contractor's notification will state, on the basis of the most accurate information then available to the Contractor, the following:

- 1) That it is a dispute pursuant to this section.
- 2) The date, nature, and circumstances of the conduct which is subject of the dispute.
- 3) The names, phone numbers, function, and activity of each Contractor, subcontractor, DHCS/State official or employee involved in or knowledgeable about the conduct.
- 4) The identification of any documents and the substances of any oral communications involved in the conduct. Copies of all identified documents will be attached.
- 5) The reason the Contractor is disputing the conduct.
- 6) The cost impact to the Contractor directly attributable to the alleged conduct, if any.
- 7) The Contractor's desired remedy.

The required documentation, including cost impact data, will be carefully prepared and submitted with substantiating documentation by the Contractor. This documentation will serve as the basis for any subsequent appeal.

Following submission of the required notification, with supporting documentation, the Contractor will comply with the requirements of Title 22 CCR Section 53851(d) and diligently continue performance of this contract, including matters identified in the Notification of Dispute, to the maximum extent possible.

c. Contracting Officer's or Alternate Dispute Officer's Decision

Pursuant to a request by Contractor, the Contracting Officer may provide for a dispute to be decided by an alternate dispute officer designated by DHCS, who is not the Contracting Officer and is not directly involved in the Medi-Cal Dental Managed Care Program. Any disputes concerning performance of this contract shall be decided by the Contracting Officer or the alternate dispute officer in a written decision stating the factual basis for the decision. Within thirty (30) calendar days of receipt of a Notification of Dispute, the Contracting Officer or the alternate dispute officer shall either:

d. Find in favor of Contractor, in which case the Contracting Officer or alternate dispute officer may:

- 1) Countermand the earlier conduct which caused Contractor to file a dispute; or
 - 2) Reaffirm the conduct and, if there is a cost impact sufficient to constitute a change in obligations pursuant to the payment provisions contained in Exhibit B, Budget Detail and Payment, direct DHCS to comply with that Exhibit.
- Or,

e. Deny Contractor's dispute and, where necessary, direct the manner of future performance; or

f. Request additional substantiating documentation in the event the information in Contractor's notification is inadequate to permit a decision to be made under 1) or 2) above, and shall advise Contractor as to what additional information is required, and establish how that information shall be furnished. Contractor shall have thirty (30) calendar days to respond to the Contracting Officer's or alternate dispute officer's request for further information. Upon receipt of this additional requested information, the Contracting Officer or alternate dispute officer shall have thirty (30) calendar days to respond with a decision. Failure to supply additional information required by the Contracting Officer or alternate dispute officer within the time period specified above shall constitute waiver by Contractor of all claims in accordance with Paragraph i. Waiver of Claims, below.

A copy of the decision shall be served on Contractor.

g. Appeal of Contracting Officer's or Alternate Dispute Officer's Decision

Contractor shall have thirty (30) calendar days following the receipt of the decision to file an appeal of the decision to the Director. All appeals shall be governed by Health and Safety Code Section 100171, except for those provisions of Section 100171(d)(1) relating to accusations, statements of issues, statement to respondent, and notice of defense. All appeals shall be in writing and shall be filed with DHCS' Office of Administrative Hearings and Appeals. An appeal shall be deemed filed on the date it is received by the Office of Administrative Hearings and Appeals. An appeal shall specifically set forth each issue in dispute, and include Contractor's contentions as to those issues. However, Contractor's appeal shall be limited to those issues raised in its Notification of Dispute filed pursuant to Paragraph b. Notification of Dispute above. Failure to timely appeal the decision shall constitute a waiver by Contractor of all claims arising out of that conduct, in accordance with Paragraph i, Waiver of Claims below, Contractor shall exhaust all procedures provided for in this Provision 4, Dispute Resolution Process, prior to initiating any other action to enforce this Contract.

h. Contractor Duty to Perform

Pending final determination of any dispute hereunder, Contractor shall comply with the requirements of Title 22 CCR Section 53851 (d) and proceed diligently with the performance of this Contract and in accordance with the Contracting Officer's or alternate dispute officer's decision.

If pursuant to an appeal under Paragraph g. Appeal of Contracting Officer's or Alternate Dispute Officer's Decision above, the Contracting Officer's or alternate dispute officer's decision is reversed, the effect of the decision pursuant to Paragraph g. shall be retroactive to the date of the Contracting Officer's or alternate dispute officer's decision, and Contractor shall promptly receive any benefits of such decision. DHCS shall not pay interest on any amounts paid pursuant to a Contracting Officer's or alternate dispute officer's decision or any appeal of such decision, or any subsequent court decision or court order regarding the subject matter of the Notification of Dispute.

i. Waiver of Claims

If Contractor fails to submit a Notification of Dispute, supporting and substantiating documentation, any additionally required information, or an appeal of the Contracting Officer's or alternate dispute officer's decision, in the manner and within the time specified in this Provision 4, Dispute Resolution Process, that failure shall constitute a waiver by Contractor of all claims arising out of that conduct, whether direct or consequential in nature.

5. Governing Law

In addition to Exhibit C, Provision 14, Governing Law, Contractor also agrees to the following:

- a. If it is necessary to interpret this contract, all applicable laws may be used as aids in interpreting the contract. However, the parties agree that any such applicable laws shall not be interpreted to create contractual obligations upon DHCS or Contractor, unless such applicable laws are expressly incorporated into this contract in some section other than this Provision, Governing Law. Except for Provision 18, Sanctions, and Provision 19, Liquidated Damages Provision, the parties agree that any remedies for DHCS' or Contractor's non-compliance with laws not expressly incorporated into this contract, or any covenants judicially implied to be part of this contract, shall not include money damages, but may include equitable remedies such as injunctive relief or specific performance. This contract is the product of mutual negotiation, and if any ambiguities should arise in the interpretation of this contract, both parties shall be deemed authors of this contract.
- b. Any provision of this contract that is in conflict with current or future applicable Federal or State laws or regulations is hereby amended to conform to the provisions of those laws and regulations. Such amendment of the contract shall be effective on the effective date of the statutes or regulations necessitating it, and shall be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

Such amendment may constitute grounds for termination of this contract in accordance with the procedures and provisions of Provision 3, Subprovision c, Termination Without Cause -

Contractor. The parties shall be bound by the terms of the amendment until the effective date of the termination.

- c. The final Balanced Budget Act of 1997 regulations are published in the Federal Register/ Volume 67, Number 115/June 14, 2002, at 42 Code of Federal Regulations, Parts 400, 430, 431, 434, 435, 438, 440 and 447. Contractor shall be in compliance with the final Balance Budget Act of 1997 regulations by August 13, 2003.
- d. All Plan Letters issued by Medi-Cal Dental Services Division (MDSD), Dental Managed Care (DMC) are hereby incorporated into this contract and shall be complied with by Contractor. All Plan Letters issued by MDSD subsequent to the effective date of this Contract shall provide clarification of Contractors obligations pursuant to this contract, and may include instructions to the Contractor regarding implementation of mandated obligations pursuant to changes in State or federal statutes or regulations, or pursuant to judicial interpretation.

In the event DHCS determines that there is an inconsistency between this contract and an All Plan Letter, the All Plan Letter shall prevail.

6. Entire Agreement

This written contract and all documents incorporated by reference shall constitute the entire agreement between the parties. No verbal representations shall be binding on either party unless such representations are reduced to writing in an All Plan Letter, Change Order or made an amendment to the contract consistent with Exhibit E, Additional Provisions, Provision 2, Amendment Process

7. Assignment/Transfer of Contract

This contract shall not be assigned or otherwise transferred, in whole or in part, without the express written consent of DHCS and amendment of the Contract. Contractor acknowledges that DHCS may not grant such consent, within six (6) months after this Contract's effective date or within six (6) months prior to its expiration date.

8. Change Requirements

a. General Provisions

The parties recognize that during the life of this contract, the Medi-Cal Managed Care program will be a dynamic program requiring numerous changes to its operations and that the scope and complexity of changes will vary widely over the life of the contract. The parties agree that the development of a system which has the capability to implement such changes in an orderly and timely manner is of considerable importance. Such changes shall be implemented by amendment to this contract in accordance with Exhibit E, Additional Provisions, Provision 2, Amendment Process.

b. Contractor's Obligation to Implement

The Contractor will make changes mandated by DHCS. In the case of mandated changes in regulations, statutes, Federal guidelines, or judicial interpretation, DHCS may direct the Contractor to immediately begin implementation of any change by issuing a contract amendment. If DHCS issues a contract amendment, the Contractor will be obligated to

implement the required changes while discussions relevant to any capitation rate adjustment, if applicable, are taking place. DHCS may, at any time, within the general scope of the contract, by written notice, issue contract amendments to the contract.

c. **Moral or Religious Objections to Providing a Service**

If the Contractor has a moral or religious objection to providing a service or referral for a service for which the Contractor is not responsible, during the term of this agreement, the Contractor shall notify the DHCS in writing providing sufficient detail to establish the moral or religious grounds for the objection.

d. **Adhoc Reporting**

During the life of this contract, DHCS reserves the right to submit written requests to the Contractor for additional Adhoc reports. Contractor must provide a written acknowledgement of the request within the required timeframe set by DHCS.

9. Delegation of Authority

DHCS intends to implement this contract through a single administrator, called the "Contracting Officer." DHCS will designate the Contracting Officer. The Contracting Officer, on behalf of DHCS, will make all determinations and take all actions as are appropriate under this contract, subject to the limitations of applicable Federal and State laws and regulations.

Contractor will designate a single administrator, called the "Contractor's Representative." Contractor shall designate Contractor's Representative in writing and shall notify the Contracting Officer in accordance with Exhibit E, Additional Provisions, Provision 13, Notices. The Contractor's Representative will make all determinations and take all actions as are appropriate to implement this contract, subject to the limitations of applicable Federal and State laws and regulations. The Contractor's Representative may delegate his/her authority to act to an authorized representative through written notice to the Contracting Officer. The Contractor's Representative, or authorized representative if applicable, will be empowered to legally bind the Contractor to all agreements reached with the State.

10. Authority of the State

Sole authority to establish, define, or determine the reasonableness, the necessity and level and scope of covered benefits under the Medi-Cal Dental Managed Care Program administered in this contract or coverage for such benefits, or the eligibility of the beneficiaries or providers to participate in the Medi-Cal Dental Managed Care Program resides with the State.

Sole authority to establish or interpret policy and its application related to the above areas will reside with the State.

The Contractor may not make any limitations, exclusions, or changes in benefits or benefit coverage; any changes in definition or interpretation of benefits; or any changes in the administration of the contract related to the scope of benefits, allowable coverage for those benefits, or eligibility of beneficiaries or providers to participate in the program without the express, written direction or approval of the Contracting Officer.

11. Fulfillment of Obligations

Contractor shall comply with all applicable requirements specified in Federal and State laws and regulations. No covenant, condition, duty, obligation, or undertaking continued or made a part of this contract will be waived except by written agreement of the parties hereto. Forbearance or indulgence in any other form or manner by either party in any regard whatsoever will not constitute a waiver of the covenant, condition, duty, obligation, or undertaking to be kept, performed or discharged by the party to which the same may apply; and, until performance or satisfaction of all covenants, conditions, duties, obligations, and undertakings is complete, the other party will have the right to invoke any remedy available under this contract, or under law, notwithstanding such forbearance or indulgence.

12. Data Certifications

Contractor shall comply with data certification requirements set forth in 42 CFR 438.604 and 42 CFR 438.606.

With respect to any report, invoice, record, papers, documents, books of account, or other contract required data submitted, pursuant to the requirements of this contract, the Contractor's ~~Representative~~ **Chief Executive Officer (CEO), Chief Financial Officer (CFO)** or his/her designee will certify, under penalty of perjury, that the report, invoice, record, papers, documents, books of account or other contract required data is current, accurate, complete and in full compliance with legal and contractual requirements to the best of that individual's knowledge and belief. **The CEO and CFO are ultimately responsible for the certification.**

13. Notices

All notices to be given under this contract will be in writing and will be deemed to have been given when received by DHCS or the Contractor:

Department of Health Care Services
Chief, Medi-Cal Dental Services Division
MS 4900, P.O. Box 997413
Sacramento, CA 95899-7413
~~11155 International Drive, Bldg. C~~
~~Rancho Cordova, CA 95670~~

Contractor Name and Address
Attn: Contractor Representative

14. Term

- a. The contract will become effective January 1, 2013, and will continue in full force and effect through July 31, 2016 subject to the provisions of Exhibit B, Provision A, Budget Contingency Clause and Exhibit D(F), Provision 9, Federal Contract Funds.
- b. The term of the contract consists of the following three periods:
 - 1) The Implementation Period, which ends as of the effective date of this contract;
 - 2) The Operations Period shall commence at the conclusion of the Implementation Period, January 1, 2013 through December 31, 2015, subject to DHCS acceptance of the Contractor's readiness to begin the Operations Period. The term of the Operations Period is subject to the termination provisions of Provision 3, Termination, and Provision 18,

Sanctions, and subject to the limitation provisions of Exhibit B, Provision A, Budget Contingency Clause and Exhibit D(F); and;

- 3) The Phase-out Period shall extend for seven (7) months from the end of the Operations Period or contract extension period.
- c. If Contractor has begun Operations as of the effective date of this contract, the term of the contract consists of the Operations Period and the Phaseout Period. The term of the Operations Period is subject to the termination provisions of Provision 3, Termination, and Provision 18, Sanctions, below and subject to the limitation provisions of Exhibit B, Provision A, Budget Contingency Clause. The Phaseout Period shall extend for seven (7) months from the end of the Operations Period, subject to Provision 15, Contract Extension, below, in which case the Phaseout Period shall begin with the first day after the end of the Extension Period and continue for seven (7) months.

15. Contract Extension

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

Contractor will provide written notification to DHCS of its intent to accept or reject the extension within ten (10) business days of the receipt of the notice from DHCS.

16. Service Area

The Service Area covered under this Contract includes:

Sacramento County

17. Phaseout Requirements

- a. DHCS shall retain a phaseout withhold, equal to the lesser amount of either 10% of the last month's service area capitation payment or \$1,000,000 for the service area unless provided otherwise by the Financial Performance Guarantee, from the capitation payment of the last month of the Operations Period for the service area until all activities required during the Phaseout Period for the service area are fully completed to the satisfaction of DHCS, in its sole discretion.

If all Phaseout activities for the service area are completed by the end of the Phaseout Period, the phaseout withhold amount will be paid to the Contractor. If the Contractor fails to meet any requirement(s) by the end of the Phaseout Period for the service area, DHCS will deduct the costs of the remaining activities from the withhold amount and continue to withhold payment until all activities are completed.

- b. The objective of the Phaseout Period is to ensure that, at the termination of this contract, the orderly transfer of necessary data and history records is made from the Contractor to DHCS or to a successor Contractor, if applicable. The Contractor shall not provide services to Members

during the Phaseout Period.

Ninety (90) calendar days prior to termination or expiration of this contract and through the Phaseout Period for the service area, the Contractor shall assist DHCS in the transition of Members, and in ensuring, to the extent possible, continuity of Member-Provider relationships. In doing this, the Contractor will make available to DHCS copies of dental records, patient files, and any other pertinent information, including information maintained by any subcontractor, necessary for efficient case management of Members, as determined by the Director. In no circumstances will a Medi-Cal Member be billed for this activity.

- c. Phaseout for this contract will consist of the processing, payment and monetary reconciliation(s) necessary regarding claims for payment for covered services.

Phaseout for the contract will consist of the completion of all financial and reporting obligations of the Contractor. The Contractor will remain liable for the processing and payment of invoices and other claims for payment for covered services and other services provided to Members pursuant to this contract prior to the expiration or termination. The Contractor will submit to DHCS all reports required under this contract for the period from the last submitted report through the expiration or termination date.

All data and information provided by the Contractor will be accompanied by letter, signed by the responsible authority, certifying, under penalty of perjury, to the accuracy and completeness of the materials supplied.

- d. Phaseout Period will commence on the date the Operations Period of the contract or contract extension ends. Phaseout related activities are non-payable items.
- e. Contractor shall submit a final undisputed payment invoice as soon as practical, following this contract's expiration or termination date, but no later than seven (7) months following the expiration or termination date of this contract, unless a later or alternate deadline is accepted in writing by DHCS in response to a request submitted by Contractor prior to this contract's expiration or termination date. The invoice must be clearly marked "Final Invoice" and accompanied by the Contractor's Release form in Exhibit F, to indicate that all payment obligations of DHCS under this contract have been fulfilled and no further payments are due or outstanding.

DHCS, at its discretion, may elect not to honor any delinquent final invoice if the Contractor fails to obtain prior written DHCS acceptance of an alternate final invoice submission deadline.

18. Sanctions

Contractor is subject to sanctions and civil penalties taken pursuant to Welfare and Institutions Code Section 14304 and 22 CCR 53872, however, such sanctions and civil penalties may not exceed the amounts allowable pursuant to 42 CFR 438.704. If required by DHCS, Contractor shall ensure subcontractors cease specified activities, which may include, but are not limited to, referrals, assignment of beneficiaries, and reporting, until DHCS determines that Contractor is again in compliance. **Except as provided in 42 CFR 438.706(c), 42 CFR 438.710 provides that before imposing any of the intermediate sanctions specified, DHCS must give the affected entity timely written notice that explains the basis and nature of the action and any other appeal rights the state has elected to provide.**

- a. Determination of non-compliance may be based on findings from onsite surveys, enrollee or other complaints, financial status, or any other source. In the event DHCS finds Contractor non-compliant with any provisions of this contract, applicable statutes or regulations, DHCS may impose sanctions provided in Welfare and Institutions Code Section 14304 and 22 CCR 53872 as modified for purposes of this contract. 22 CCR 53872 is so modified as follows:
- 1) Subsection (b)(1) is modified by replacing “Article 2” with “Article 6”
 - 2) Subsection (b)(2) is modified by replacing “Article 3” with “Article 7”
- b. A contractor may request a hearing in connection with any sanctions applied pursuant to Welfare and Institutions Code Section 14304(b) in addition to temporary suspension orders within 15 working days of notice by sending a letter to the address in said notice. DHCS shall stay implementation of the sanction upon receipt of the request for a hearing. Implementation shall remain stayed until the effective date of DHCS’s final determination.
- c. Sanctions for violations of the requirements of Exhibit A, Attachment 5, Quality Improvement System, shall be governed by Subsection 53872 (b)(4).
- d. For purposes of sanctions, good cause includes, but is not limited to, the following:
- 1) Three (3) repeated and uncorrected findings of serious deficiencies that have the potential to endanger patient care identified in the dental audits conducted by DHCS.
 - 2) In the case of Exhibit A, Attachment 6, Performance Measures and Benchmarks, the Contractor consistently fails to achieve the minimum performance benchmarks, or receives a “Not Reported” designation on a performance measure, after implementation of corrective actions.
 - 3) A substantial failure to provide medically necessary covered services required under this contract or law to a Member.
 - 4) Imposition on Members of premiums or charges that are in excess of the premiums or charges permitted under the Medi-Cal program.
 - 5) Acts to discriminate among Members on the basis of their health status or need for services, including both termination of existing enrollment and refusal or discouragement of (re)enrollment.
 - 6) Misrepresentation or falsification of information furnished to CMS or to DHCS.
 - 7) Misrepresentation or falsification of information furnished to a Member, potential Member, or health care provider.
 - 8) Non-compliance with the contract or applicable Federal and State law or regulation.
 - 9) Violation of any of the requirements under sections 1903(m) or 1932 of the Social Security Act.

-
- 10) Failure to comply with requirements for physician incentive plans as set forth in 42 CFR 422.208 and 422.210.
 - 11) The direct or indirect distribution of marketing materials that have not been approved by DHCS, or that contain false or materially misleading information.
 - 12) Contractor has accrued claims that have not or will not be recompensed.
- d. Upon determinations of non-compliance, DHCS may impose the following sanctions:
- 1) Granting and notification of Members the right to terminate enrollment without cause.
 - 2) Suspension of all new enrollment after the date the Contractor is notified of a violation under sections 1903(m) or 1932 of the Social Security Act.
 - 3) Suspension of payment for Members enrolled after the effective date of the sanction and until CMS or DHCS is satisfied that the basis for the sanction no longer exists and is not likely to recur.
- e. The following intermediate sanctions may be imposed due to lack of compliance in all cases except for violations of sections 1903(m) or 1932 of the Social Security Act.
- 1) Civil money penalties pursuant as provided in this Provision.
 - 2) Appointment of temporary management as provided in Provision 3.
- f. DHCS retains authority to impose additional sanctions under State statutes or State regulations that address areas of noncompliance specified in 42 CFR 438.700, as well as additional areas of noncompliance. Nothing in this subpart prevents DHCS from exercising that authority.
- g. DHCS may make one or more of the following temporary suspension orders as an immediate sanction, effective no earlier than 20 days after the notice:
- 1) Suspend marketing activities.
 - 2) Require the contractor temporarily to suspend specified personnel.
 - 3) Require the contractor temporarily to suspend participation by a specified subcontractor.
- h. Upon receipt of a notice of defense filed by the contractor, DHCS shall within 15 days set the matter for hearing, no later than 30 days after the receipt of the notice of hearing by the contractor. The temporary suspension order shall remain in effect until the hearing is completed and DHCS has made a final determination. The temporary suspension order shall be deemed vacated if the Director fails to make a final determination on the merits within 60 days after the original hearing has been completed.
- i. Sanctions in the form of denial of payments provided for under this contract for new enrollees shall be taken, when and for as long as, payment for those enrollees is denied by DHHS under 42 CFR 438.730.

-
- j. The imposition of civil penalties shall be limited depending on the nature of the Contractor's non-compliance in accordance with applicable Federal and State law or regulation.
- 1) The limit is twenty-five thousand dollars (\$25,000) for each determination of failure to provide medically necessary services; misrepresentation of information furnished to Members, potential Members, or health providers; failure to comply with physician incentive plan requirements; and the distribution of unapproved or inaccurate marketing materials.
 - 2) The limit is one hundred thousand dollars (\$100,000) for each determination of discrimination among Members on the basis of their health status or health care needs; and the misrepresentation of information furnished to CMS or DHCS.
 - 3) The limit is fifteen thousand dollars (\$15,000) for each beneficiary the State determines was not enrolled due to discriminatory practices.
 - 4) The limit is twenty-five thousand dollars (\$25,000) or double the amount of the excess charges for each determination of that Members' premiums or charges are in excess of the premiums or charges permitted under Medi-Cal.
- k. The Director shall have the power and authority to take one or more of the following sanctions against Contractor for noncompliance:
- 1) Appointment of temporary management if Contractor has repeatedly failed to meet the contractual requirements or applicable Federal and State law or regulation. Contractor cannot delay appointment of temporary management to provide a hearing before appointment. Temporary management will not be terminated until DHCS determines that Contractor's sanctioned behavior will not recur.
 - 2) Suspension of all new enrollment, including default enrollment, or marketing activities after the effective date of the sanction;
 - 3) Require Contractor to temporarily suspend or terminate personnel or subcontractors.
 - 4) Impose additional civil penalties if the Contractor violates any federal or state statute or regulation, or any provision of its contract with DHCS, as follows:
 - a) Five thousand dollars (\$5,000) for the first violation.
 - b) Ten thousand dollars (\$10,000) for the second violation.
 - c) The limit is twenty-five thousand dollars (\$25,000) for each subsequent violation.
 - 5) Collect civil penalties by withholding the amount from capitation owed to the Contractor.
 - 6) Take other appropriate action as determined necessary by DHCS.

19. Liquidated Damages Provisions

a. General

It is agreed by the State and Contractor that:

- 1) If Contractor does not provide or perform the requirements of this contract or applicable laws and regulations, damage to the State shall result;
 - a) Proving such damages shall be costly, difficult, and time-consuming;
 - b) Should the State choose to impose liquidated damages, Contractor shall pay the State those damages for not providing or performing the specified requirements within thirty (30) calendar days of notice;
 - c) Additional damages may occur in specified areas by prolonged periods in which Contractor does not provide or perform requirements;
 - d) The damage figures listed below represent a good faith effort to quantify the range of harm that could reasonably be anticipated at the time of the making of the contract;
 - e) DHCS may, at its discretion, offset liquidated damages from capitation payments owed to Contractor;
- 2) Imposition of liquidated damages as specified in Subprovision b, Liquidated Damages for Violation of Contract Terms Regarding the Implementation Period, and c, Liquidated Damages for Violation of Contract Terms or Regulations Regarding the Operations Period, shall follow the administrative processes described below;
- 3) Before imposing sanctions, DHCS shall provide Contractor with written notice specifying the Contractor requirement(s), contained in the contract or as required by federal and State law or regulation, not provided or performed;
- 4) During the Implementation Period, Contractor shall submit or complete the outstanding requirement(s) specified in the written notice within five (5) business days from the date of the notice, unless, subject to the Contracting Officer's written approval, Contractor submits a written request for an extension. The request must include the following: the requirement(s) requiring an extension; the reason for the delay; and the proposed date of the submission of the requirement.
- 5) During the Implementation Period, if Contractor has not performed or completed an Implementation Period requirement or secured an extension for the submission of the outstanding requirement, DHCS may impose liquidated damages for the amount specified in Subprovision b, Liquidated Damages for Violation of Contract Terms Regarding the Implementation Period.
- 6) During the Operations Period, Contractor shall demonstrate the provision or performance of Contractor's requirement(s) specified in the written notice within a thirty (30) calendar day corrective action period from the date of the notice, unless a request for an extension is submitted to the Contracting Officer, subject to DHCS' approval, within five (5) calendar days from the end of the corrective action period. If Contractor has not demonstrated the provision or performance of Contractor's requirement(s) specified in the written notice during

the corrective action period, DHCS may impose liquidated damages for each day the specified Contractor's requirement is not performed or provided for the amount specified in Subprovision c, Liquidated Damages for Violation of Contract Terms or Regulations Regarding the Operations Period.

- 7) During the Operations Period, if Contractor has not performed or provided Contractor's requirement(s) specified in the written notice or secured the written approval for an extension, after thirty (30) calendar days from the first day of the imposition of liquidated damages, DHCS shall notify Contractor in writing of the increase of the liquidated damages to the amount specified in Subprovision c, Liquidated Damages for Violation of Contract Terms or Regulations Regarding the Operations Period.

Nothing in this Provision shall be construed as relieving Contractor from performing any other contract duty not listed herein, nor is the State's right to enforce or to seek other remedies for failure to perform any other contract duty hereby diminished.

- b. Liquidated Damages for Violation of Contract Terms Regarding the Implementation Period

DHCS may impose liquidated damages of \$25,000 per requirement specified in the written notice for each day of the delay in completion or submission of Implementation Period requirements beyond the Implementation Period as specified in Provision 14, Term above.

If DHCS determines that a delay or other non-performance was caused in part by the State, DHCS will reduce the liquidated damages proportionately.

- c. Liquidated Damages for Violation of Contract Terms or Regulations Regarding the Operations Period

- 1) Site Reviews

DHCS may impose liquidated damages of \$2,500 per day for each violation of contract requirement not performed in accordance with Exhibit A, Attachment 5, Quality Improvement System, Provision K, Site Review, until the contract requirement is performed or provided.

- 2) Third-Party Tort Liability

DHCS may impose liquidated damages of \$3,500 per instance or case, per Medi-Cal Member if a Contractor fails to deliver the requested information in accordance with Provision 25, Third-Party Tort Liability.

- 3) Plan Provider Availability

DHCS may impose liquidated damages of \$3,500 per violation of contract requirement not performed in accordance with Exhibit A, Attachment 8, Provider Network, Provision F, Adequate Facilities and Personnel.

- 4) Security and Confidentiality

DHCS may impose liquidated damages of \$2,500 per day, until Contractor has corrected the deficiency, if Contractor fails to comply with Exhibit A, Attachment 4, Management Information System, Provision D, HIPAA requirements.

d. Conditions for Termination of Liquidated Damages

Except as waived by the Contracting Officer, no liquidated damages imposed on the Contractor will be terminated or suspended until the Contractor issues a written notice of correction to the Contracting Officer certifying, under penalty of perjury, the correction of condition(s) for which liquidated damages were imposed. Liquidated damages will cease on the day of the Contractor's certification only if subsequent verification of the correction by DHCS establishes that the correction has been made in the manner and at the time certified to by the Contractor.

The Contracting Officer will determine whether the necessary level of documentation has been submitted to verify corrections. The Contracting Officer will be the sole judge of the sufficiency and accuracy of any documentation. Corrections must be sustained for a reasonable period of at least ninety (90) calendar days from DHCS acceptance; otherwise, liquidated damages may be reimposed without a succeeding grace period within which to correct. The Contractor's use of resources to correct deficiencies will not be allowed to cause other contract compliance problems.

e. Severability of Individual Liquidated Damages Clauses

If any portion of these liquidated damages provisions is determined to be unenforceable, the other portions will remain in full force and effect.

20. Audit

In addition to Exhibit C, Provision 4, Audit, Contractor also agrees to the following:

The Contractor will maintain such books and records necessary to disclose how the Contractor discharged its obligations under this contract. These books and records will disclose the quantity of covered services provided under this contract, the quality of those services, the manner and amount of payment made for those services, the persons eligible to receive covered services, the manner in which the Contractor administered its daily business, and the cost thereof.

a. Books and Records

These books and records will include, but are not limited to, all physical records originated or prepared pursuant to the performance under this contract including subcontracts, working papers; reports submitted to DHCS; financial records; all dental records, charts and prescription files; and other documentation pertaining to dental and non-dental services rendered to Members.

b. Records Retention

Notwithstanding any other records retention time period set forth in this contract, **Contractor shall retain, and require subcontractors to retain** these books and records, **including member grievance and appeal records in 42 CFR § 438.416, base data in 42 CFR §438.5(c), MLR reports in 42 CFR §438.8(k), and the data, information, and documentation specified in 42 CFR §§ 438.604, 438.606, 438.608, and 438.610** ~~will be maintained~~ for a minimum of ~~five (5)~~ **ten (10)** years from the end of the current fiscal year in which the date of service occurred, unless a longer period is required by law; in which the

record or data was created or applied; and for which the financial record was created or the contract is terminated, or, in the event the Contractor has been duly notified that DHCS, DHHS, Department of Justice (DOJ), or the Comptroller General of the United States, or their duly authorized representatives, have commenced an audit or investigation of the contract, until such time as the matter under audit or investigation has been resolved, whichever is later.

21. Monitoring Requirements

- a. **The Contractor must comply with any State-conducted readiness review.**
- b. **Readiness reviews must include both a desk review of documents and on-site reviews of the Contractor. Readiness reviews described in paragraph c of this section must include a desk review of documents and may, at DHCS's option, include an on-site review. On-site reviews must include interviews with the Contractor staff and leadership that manage key operational areas.**
- c. **The DHCS readiness review will assess the ability and capacity of Contractor (if applicable) to perform satisfactorily for the following areas:**
 - 1) **Operations/Administration, including:**
 - a) **Administrative staffing and resources.**
 - b) **Delegation and oversight of MCO, PIHP, PAHP or PCCM entity responsibilities.**
 - c) **Member and provider communications.**
 - d) **Grievance and appeals.**
 - e) **Member services and outreach.**
 - f) **Provider Network Management.**
 - g) **Program Integrity/Compliance.**
 - 2) **Service delivery, including:**
 - a) **Case management/care coordination/service planning.**
 - b) **Quality improvement.**
 - c) **Utilization review.**
 - 3) **Financial management, including:**
 - a) **Financial reporting and monitoring.**
 - b) **Financial solvency.**
 - 4) **Systems management, including:**
 - a) **Claims management.**
 - b) **Encounter data and enrollment information management.**

22. ~~24.~~Inspection Rights

In addition to Exhibit D (F), Provision 8, Site Inspection, Contractor also agrees to the following:

Through the end of the records retention period specified in Provision 20, Audit, Subprovision b, Records Retention, Contractor shall allow the DHCS, DHHS, the Comptroller General of the United States, DOJ, Bureau of Medi-Cal Fraud, Department of Managed Health Care (DMHC), and other authorized State agencies, or their duly authorized representatives, to inspect, monitor or otherwise evaluate the quality, appropriateness, and timeliness of services performed under this contract, and to inspect, evaluate, and audit any and all books, records, and facilities maintained by Contractor and subcontractors pertaining to these services at any time during normal business hours.

Books and records include, but are not limited to, all physical records originated or prepared pursuant to the performance under this contract, including working papers, reports, financial records, and books of account, dental records, prescription files, subcontracts, information systems and procedures, and any other documentation pertaining to dental and non-dental services rendered to Members. Upon request, through the end of the records retention period specified in Provision 20, Audit, Subprovision b, Records Retention, Contractor shall furnish any record, or copy of it, to DHCS or any other entity listed in this section, at Contractor's sole expense.

a. Facility Inspections

DHCS shall conduct unannounced validation reviews of the Contractor's primary care or other service sites, selected at DHCS' discretion, to verify compliance of these sites with State and Federal regulations and contract requirements.

b. Access Requirements and State's Right To Monitor

Authorized State and Federal agencies will have the right to monitor all aspects of the Contractor's operation for compliance with the provisions of this contract and applicable federal and State laws and regulations. Such monitoring activities will include, but are not limited to, inspection and auditing of Contractor, subcontractor, and provider facilities, management systems and procedures, and books and records as the Director deems appropriate, at any time during the Contractor's or other facility's normal business hours. The monitoring activities will be either announced or unannounced.

To assure compliance with the contract and for any other reasonable purpose, the State and its authorized representatives and designees will have the right to premises access, with or without notice to the Contractor. This will include the MIS operations site or such other place where duties under the contract are being performed.

Staff designated by authorized State agencies will have access to all security areas and the Contractor will provide, and will require any and all of its subcontractors to provide, reasonable facilities, cooperation and assistance to State representative(s) in the performance of their duties. Access will be undertaken in such a manner as to not unduly delay the work of the Contractor and/or the subcontractor(s).

23. ~~22.~~Confidentiality of Member Information

In addition to Exhibit D (F), Provision 13, Confidentiality of Information and Exhibit G, Health Insurance Portability and Accountability Act (HIPAA), Contractor also agrees to the following duties and responsibilities with respect to confidentiality of information and data:

- a. Notwithstanding any other provision of this contract, names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with 42 CFR 431.300 et seq Welfare and Institutions Code Section 14100.2, and regulations adopted thereto. For the purpose of this contract, all information, records, data, and data elements collected and maintained for the operation of the contract and pertaining to Members shall be protected by the Contractor from unauthorized disclosure.

Contractor may release dental records in accordance with applicable law pertaining to the release of this type of information. Contractor is not required to report requests for dental records made in accordance with applicable law.

- b. With respect to any identifiable information concerning a Member under this contract that is obtained by the Contractor or its subcontractors, the Contractor: (1) will not use any such information for any purpose other than carrying out the express terms of this contract, (2) will promptly transmit to DHCS all requests for disclosure of such information, except requests for dental records in accordance with applicable law, (3) will not disclose except as otherwise specifically permitted by this contract, any such information to any party other than DHCS without DHCS' prior written authorization specifying that the information is releasable under 42 CFR 431.300 et seq., Welfare and Institutions Code Section 14100.2, and regulations adopted there under, and (4) will, at the termination of this contract, return all such information to DHCS or maintain such information according to written procedures sent to the Contractor by DHCS for this purpose.

24. ~~23.~~Pilot Projects

DHCS may establish pilot projects to test alternative managed care models tailored to suit the needs of populations with special health care needs. The operation of these pilot projects may result in the disenrollment of Members that participate. Implementation of a pilot project may affect the Contractor's obligations under this contract. Any changes in the obligations of the Contractor that are necessary for the operation of a pilot project in the contractor's service area will be implemented through a contract amendment, in accordance with Exhibit E, Additional Provisions, Provision 2, Amendment Process.

25. ~~24.~~Cost Avoidance and Post-Payment Recovery of Other Health Coverage Sources (OHCS)

- a. Contractor shall cost avoid or make a post-payment recovery for the reasonable value of services paid for by Contractor and rendered to a Member whenever a Member's OHCS covers the same services, either fully or partially. However, in no event shall Contractor cost avoid or seek post-payment recovery for the reasonable value of services from a Third-Party Tort Liability (TPTL) action or make a claim against the estates of deceased Members.
- b. Contractor retains all OHCS monies recovered by Contractor.
- c. Contractor shall coordinate benefits with other coverage programs or entitlements, recognizing the OHCS as primary and the Medi-Cal program as the payor of last resort.

d. Cost Avoidance

- 1) If Contractor reimburses the provider on a fee-for-service basis, Contractor shall not pay claims for services provided to a Member whose Medi-Cal eligibility record indicates third party coverage, designated by Other Health Coverage (OHC) code or Medicare coverage, without proof that the provider has first exhausted all sources of other payments. Contractor shall have written procedures implementing this requirement.
- 2) Proof of third party billing is not required prior to payment for services provided to Members with OHC codes A, M, X, Y, or Z.

e. Post-Payment Recovery

- 1) If Contractor reimburses the provider on a fee-for-service basis, Contractor shall pay the provider's claim and then seek to recover the cost of the claim by billing the OHCS:
 - a) For services provided to Members with OHC codes A, M, X, Y, or Z;
 - b) For services defined by DHCS as prenatal or pediatric preventive services; or
 - c) In child-support enforcement cases, identifiable by Contractor. If Contractor does not have access to sufficient information to determine whether or not the OHC is the result of a child enforcement case, Contractor shall follow the procedures for cost avoidance.
- 2) In instances where Contractor does not reimburse the provider on a fee-for-service basis, Contractor shall pay for services provided to a Member whose eligibility record indicates third party coverage, designated by an OHC code or Medicare coverage, and then shall bill the OHCS for the cost of actual services rendered.
- 3) Contractor shall also bill the OHCS for the cost of services provided to Members who are retroactively identified by Contractor or DHCS as having OHC.
- 4) Contractor shall have written procedures implementing the above requirements.

f. Reporting Requirements

- 1) Contractor shall maintain reports that display claims counts and dollar amounts of costs avoided and the amount of post-payment recoveries, by aid category, as well as the amount of outstanding recovery claims (accounts receivable) by age of account. The report shall display separate claim counts and dollar amounts for Medicare Part A and Part B. Reports shall be made available upon DHCS request.
- 2) When Contractor identifies OHC unknown to DHCS, Contractor shall report this information to DHCS within ten (10) calendar days of discovery in automated format as prescribed by DHCS. This information shall be sent to the Department of Health Care Services, Third Party Liability Branch, Other Coverage Unit, P.O. Box 997422, Sacramento, CA 95899-7422.

- 3) Contractor shall demonstrate to DHCS that where Contractor does not cost avoid or perform post-payment recovery that the aggregate cost of this activity exceeds the total revenues Contractor projects it would receive from such activity.

26. ~~25.~~Third-Party Tort Liability

Contractor shall identify and notify DHCS' Third Party Liability Branch of all instances or cases in which Contractor believes an action by the Medi-Cal Member involving casualty insurance or tort or Workers' Compensation liability of a third party could result in recovery by the Member of funds to which DHCS has lien rights under Article 3.5 (commencing with Section 14124.70), Part 3, Division 9, Welfare and Institutions Code. Contractor shall make no claim for recovery of the value of covered services rendered to a Member in such cases or instances and such case or instance shall be referred to DHCS' Third Party Liability Branch within ten (10) calendar days of discovery. To assist DHCS in exercising its responsibility for such recoveries, Contractor shall meet the following requirements:

- a. If DHCS requests service information and/or copies of paid invoices/claims for covered services to an individual Member, Contractor shall deliver the requested information within thirty (30) calendar days of the request. Service information includes subcontractor and out-of-plan provider data. The value of the covered services shall be calculated as the usual, customary and reasonable charge made to the general public for similar services or the amount paid to subcontracted providers or out-of-plan providers for similar services.
- b. Information to be delivered shall contain the following data items:
 - 1) Member name
 - 2) Full 14 digit Medi-Cal number
 - 3) Medi-Cal Beneficiary Identification Number
 - 4) Date of birth
 - 5) Contractor name
 - 6) Provider name (if different from Contractor)
 - 7) Dates of service
 - 8) Description of illness/injury
 - 9) Procedure code and/or description of services rendered
 - 10) Amount billed by a subcontractor or out-of-plan provider to Contractor (if applicable)
 - 11) Amount paid by other health insurance to Contractor or subcontractor (if applicable)
 - 12) Amounts and dates of claims paid by Contractor to subcontractor or out-of-plan provider (if applicable)
 - 13) Date of denial and reasons for denial of claims (if applicable)

14) Date of death (if applicable)

- c. Contractor shall notify DHCS' Third Party Liability Branch in writing, the name, address and telephone number of the person responsible for receiving and complying with requests for mandatory and/or optional at-risk service information.
- d. If Contractor receives any requests from attorneys, insurers, or beneficiaries for copies of bills, Contractor shall refer the request to Third Party Liability Branch with the information contained in Subprovision b, above, and shall provide the name, address and telephone number of the requesting party.
- e. Information submitted to DHCS under this section shall be sent to Department of Health Care Services, Third Party Liability Branch, Recovery Section, ~~P.O. Box 2471, Sacramento, CA 95812-2471~~ **MS 4720, P.O. Box 997425, Sacramento, CA 95899-7425.**

27. ~~26.~~Records Related to Recovery for Litigation

a. Records

Upon request by DHCS, Contractor shall timely gather, preserve and provide to DHCS, in the form and manner specified by DHCS, any information specified by DHCS, subject to any lawful privileges, in Contractor's or its subcontractors' possession, relating to threatened or pending litigation by or against DHCS. If Contractor asserts that any requested documents are covered by a privilege, Contractor shall: 1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and 2) state the privilege being claimed that supports withholding production of the document. Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against DHCS. Contractor acknowledges that time may be of the essence in responding to such request. Contractor shall use all reasonable efforts to immediately notify DHCS of any subpoenas, document production requests, or requests for records, received by Contractor or its subcontractors related to this contract or subcontracts entered into under this contract.

b. Payment for Records

In addition to the payments provided for in Exhibit B, Budget Detail and Payment, DHCS agrees to pay Contractor for complying with Subprovision a, Records, above, as follows:

- 1) DHCS shall reimburse Contractor amounts paid by Contractor to third parties for services necessary to comply with Subprovision a. Any third party assisting Contractor with compliance with Subprovision a above shall comply with all applicable confidentiality requirements. Amounts paid by Contractor to any third party for assisting Contractor in complying with Subprovision a, shall not exceed normal and customary charges for similar services and such charges and supporting documentation shall be subject to review by DHCS.
- 2) If Contractor uses existing personnel and resources to comply with Subprovision a, DHCS shall reimburse Contractor as specified below. Contractor shall maintain and provide to DHCS time reports supporting the time spent by each employee as a condition of reimbursement. Reimbursement claims and supporting documentation shall be subject to review by DHCS.

- a) Compensation and payroll taxes and benefits, on a prorated basis, for the employees' time devoted directly to compiling information pursuant to Subprovision a.
- b) Costs for copies of all documentation submitted to DHCS pursuant to Subprovision a, subject to a maximum reimbursement of ten (10) cents per copied page.
- 3) Contractor shall submit to DHCS all information needed by DHCS to determine reimbursement to Contractor under this Provision, including, but not limited to, copies of invoices from third parties and payroll records.

28. **27.Fraud, Waste, and Abuse**

- a. For purposes of this provision, see Exhibit E, Attachment 1, Definitions, for abuse, conviction or convicted and fraud.
- b. Contractor shall meet the requirements set forth in 42 CFR § 438.608 **as well as applicable state and federal law**. Contractor shall establish an Anti-Fraud and Abuse **Compliance Program** in which there will be **written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable Federal and State standards. Contractor or subcontractor will designate a Compliance Officer as a central point of contact for all fraud and/or abuse issues, who reports to the Chief Executive Officer and board of directors.** This program will establish policies and procedures for identifying, investigating and taking appropriate action against fraud and/or abuse in the provision of health care services under the Medi-Cal Program.

1) Regulatory Compliance

Contractor shall establish a compliance committee on the board of directors that are accountable to senior management for overseeing the compliance program and who will be responsible for the following:

- a) **Effective training and education for the Compliance Officer and the organization's employees.**
- b) **Effective lines of communication between the Compliance Officer and the organization's employees.**
Enforcement of standards through well-publicized disciplinary guidelines.
- c) **Provision for internal monitoring and auditing. Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the contract.**
- d) **Provision for prompt response to detected offenses, and for development of corrective action initiatives.**

4) **2) Fraud, Waste, and Abuse Reporting**

Contractor shall report to DHCS all cases of suspected Fraud, Waste, and/or Abuse where there is reason to believe that an incident of Fraud, Waste, and/or Abuse has occurred by subcontractors, members, providers, or employees. Contractor shall conduct, complete, and promptly report to DHCS, the results of a preliminary investigation of the suspected Fraud, Waste, and/or Abuse within ten (10) business days of the date Contractor first becomes aware of, or is on notice of, such activity. The contractor shall promptly refer any identified potential fraud, waste, or abuse to DHCS' Medicaid program integrity unit/fraud control unit for DMC plans. The preliminary investigation and all documents regarding the investigation shall be reviewed by a licensed dentist.

Fraud reports submitted to DHCS must, at a minimum, include:

- a) Number of complaints of fraud and abuse submitted that warranted preliminary investigation.
- b) For each complaint which warranted a preliminary investigations, supply:
 - i. Name and/or SSN or CIN;
 - ii. Source of complaint;
 - iii. Type of provider (if applicable);
 - iv. Nature of complaint;
 - v. Approximate dollars involved; and
 - vi. Legal and administrative disposition of the case.

The report shall be submitted on a Confidential Medi-Cal Complaint Report and mailed to DHCS at:

Department of Health Care Services
Medi-Cal Dental Services Division
P.O. Box 997413, Mail Stop 47084900
Sacramento, CA 95899-7413

Contractor shall submit the following components with the report or explain why the components are not submitted with the report: Police report, Health Plan's documentation (background information, investigation report, interviews, and any additional investigative information), Member information (patient history chart, patient profile, claims detail report), provider enrollment data, confirmation of services, list items or services furnished by the provider, pharmaceutical data from manufacturers, wholesalers and retailers and any other pertinent information.

Network providers for which the State determines there is a credible allegation of fraud shall be subjected to a suspension in payments in accordance with 42 CFR § 455.23

Contractor employees shall be given written policies regarding the False Claims Act and about their rights to be protected as whistleblowers.

3) Overpayments Recovery

Contractor shall promptly report to DHCS in accordance with Exhibit E, Additional Provisions, Provision 28, Fraud, Waste, and Abuse Reporting all overpayments identified or recovered, specifying the overpayments due to potential fraud.

Contractor shall comply with 42 CFR § 438.608(d). Recoveries of overpayments to network providers due to fraud, waste, or abuse shall be reported to DHCS by the Contractor on an annual basis, including the provider name, nature of overpayment, and dollar amount for each occurrence. Contractor shall require network providers to immediately report when they have received an overpayment, ~~and~~ return the overpayment within sixty (60) calendar days from discovery of the overpayment, and notify the Contractor in writing of the reason for the overpayment. Treatment of recoveries of overpayments to DHCS shall be in accordance with Exhibit B, Budget Detail and Payment Provisions, Provision J.

4) Changes in Eligibility

Contractor shall promptly report to DHCS in accordance with Exhibit E, Additional Provisions, Provision 28, Fraud, Waste, and Abuse Reporting when it receives information about changes in a Member's circumstances that may affect the Member's eligibility including all of the following:

- a) Changes in the Member's residence.
- b) The death of a Member.

5) Delivery of Services

Contractor shall comply with 42 CFR § 438.608(a)(5). Contractor must implement and maintain arrangements or procedures that include provisions to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by Members. Contractor shall apply such verification processes on a regular basis.

2) ~~4) 6)~~ Tracking Suspended Providers

Contractor shall comply with 42 CFR 438.610. Additionally, Contractor is prohibited from employing, contracting or maintaining a contract with Dentists or other dental care providers that are excluded, suspended or terminated from participation in the Medicare or Medi-Cal/Medicaid programs. A list of suspended and ineligible providers is maintained in the Medi-Cal Provider Manual, which is updated monthly and available on line and in print at the DHCS Medi-Cal Web site (<http://www.medi-cal.ca.gov>); by the Department of Health and Human Services, Office of Inspector General, List of Excluded Individuals and Entities (<http://oig.hhs.gov>); by the Excluded Parties List System (<http://www.epls.gov>); and provider shall not be found on the Social Security Administration's Death Master File (<http://www.ssdmf.com>). Contractor is deemed to have knowledge of any providers on these lists. Contractor must notify the Medi-Cal Dental Managed Care Unit within ten (10) state business days of removing a suspended, excluded, or terminated provider from its

provider network and confirm that the provider is no longer receiving payments in connection with the Medicaid program.

3) ~~5) 7)~~ Federal False Claim Act Compliance

Contractor shall comply with 42 USC 1396a(a)(68), Employee Education About False Claims Recovery, as a condition of receiving payments under this contract. Upon request by DHCS, Contractor shall demonstrate compliance with this Provision, which may include providing DHCS with copies of Contractor's applicable written policies and procedures and any relevant employee handbook excerpts.

29. ~~28.~~Confidential Contract Terms

The terms of this contract are confidential and may be disclosed by the Contractor or its providers and subcontractors only in accordance with the disclosure time limits set forth in Government Code section 6254(q).

30. ~~29.~~Federal Nondiscrimination Requirements

Contractor shall comply with all applicable federal requirements in Section 504 of the Rehabilitation Act of 1973 (29 USC §794) Nondiscrimination under Federal grants and programs; 45 CFR 84 Nondiscrimination on the basis of handicap in programs or activities receiving Federal financial assistance; 28 CFR 36 Nondiscrimination on the basis of disability by public accommodations and in commercial facilities; Title IX of the Education Amendments of 1972 (regarding education programs and activities); 45 CFR 91 the Age Discrimination Act of 1975; and all other laws regarding privacy and confidentiality.

31. ~~30.~~No Third-Party Beneficiary – Contract

It is not the intention of DHCS or Contractor that Members occupy the position of intended third-party beneficiaries of the rights, obligations, and benefits under this contract.

32. ~~31.~~Word Usage

Unless the context of this contract clearly requires otherwise, (a) the plural and singular numbers shall each be deemed to include the other; (b) the masculine, feminine, and neuter genders shall each be deemed to include the others; (c) "shall," "will," "must," or "agrees" are mandatory, and "may" is permissive; (d) "or" is not exclusive; and (e) "includes" and "including" are not limiting.

**EXHIBIT E, ATTACHMENT 1
DEFINITIONS**

As used in this contract or other DHCS Medi-Cal Dental Managed Care contract, unless otherwise expressly provided or the context otherwise requires, the following definitions of terms will govern the construction of this contract:

Abuse means provider practices that are inconsistent with sound fiscal, business, or dental practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for dental services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program (42 CFR 455.2 and as further defined in Welf. & Inst. Code §14043.1(a).

Actuary means an individual who meets the qualification standards established by the American Academy of Actuaries for an actuary and follows the practice standards established by the Actuarial Standards Board. In this part, Actuary refers to an individual who is acting on behalf of the State when used in reference to the development and certification of capitation rates as defined in 42 CFR § 438.2

Administrative Costs means only those costs that arise out of the operation of the plan excluding direct and overhead costs incurred in the furnishing of dental care services, which would ordinarily be incurred in the provision of these services whether or not through a plan.

Affiliate means an organization or person that directly or indirectly through one or more intermediaries' controls, or is controlled by, or is under control with the Contractor and that provides services to, or receives services from, the Contractor.

All Plan Letter means a document that is dated, numbered and issued by DHCS to provide clarification of Contractor obligations pursuant to this Contract, and may include instructions to the Contractor regarding implementation of mandated obligations pursuant to changes in State or federal statutes or regulations, or pursuant to judicial interpretation

Beneficiary Assignment means the act of Department of Health Care Services (DHCS) or DHCS' enrollment contractor of notifying a beneficiary in writing of the plan in which the beneficiary shall be enrolled if the beneficiary fails to timely choose a plan. If, at any time, the beneficiary notifies DHCS or DHCS' enrollment contractor of the beneficiary's plan choice, such choice shall override the Beneficiary Assignment and be effective as provided in Exhibit A, Attachment 16, Enrollments and Disenrollments, Provision B.

Beneficiary Identification Card (BIC) means a permanent plastic card issued by the State to Medi-Cal recipients that is used by Contractors and providers to verify Medi-Cal eligibility and plan enrollment.

Business day(s) means any day that the Contractor and/or State is open for business.

California Children's Services (CCS) means those services authorized by the CCS program for the diagnosis and treatment of the CCS Eligible Conditions of a specific Member.

California Children's Services (CCS) Eligible Conditions means a physically handicapping condition defined in Title 22, California Code of Regulations (CCR), Section 41410.

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

Capitation means the method of payment in which the Contractor is paid by the State, or subcontractor is paid by Contractor, a fixed amount for a Member over a given period regardless of the actual number or nature of services delivered.

Capitation payment means a payment the State makes periodically to a contractor on behalf of each beneficiary enrolled under a contract and based on the actuarially sound capitation rate for the provision of services under the State plan. The State makes the payment regardless of whether the particular beneficiary receives services during the period covered by the payment as defined in 42 CFR § 438.2

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

Case Management means services provided by a Primary Care Dentist to ensure the coordination of medical necessary dental services, assuring the provision of preventative services in accordance with established standards and ensuring continuity of care for Medi-Cal Members. It includes treatment, planning, coordination referral, follow-up, and monitoring of appropriate services and resources required to meet an individual's dental care needs.

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

Choice counseling means the provision of information and services designed to assist beneficiaries in making enrollment decisions; it includes answering questions and identifying factors to consider when choosing among managed care plans and primary care providers. Choice counseling does not include making recommendations for or against enrollment into a specific MCO, PIHP, or PAHP.

Comprehensive risk contract means a risk contract between the State and an MCO that covers comprehensive services, that is, inpatient hospital services and any of the following services, or any three or more of the following services:

(1) Outpatient hospital services.

(2) Rural health clinic services.

(3) Federally Qualified Health Center (FQHC) services.

- (4) Other laboratory and X-ray services.
- (5) Nursing facility (NF) services.
- (6) Early and periodic screening, diagnostic, and treatment (EPSDT) services.
- (7) Family planning services.
- (8) Physician services.
- (9) Home health services.

Confidential Information means specific facts or documents identified as “confidential” by any law, regulations or contractual language.

Contract means this written agreement between DHCS and the Contractor.

Conviction or **Convicted** means that a judgment of conviction has been entered by a Federal, State, or local court, regardless of whether an appeal from that judgment is pending (42 CFR 455.2). This definition also includes the definition of the term “convicted” in Welfare and Institutions Code Section 14043.1(f).

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

Corrective Actions means specific identifiable activities or undertakings of the Contractor that address program deficiencies or problems identified by formal audits or monitoring activities by the State or its designated representatives.

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

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

Covered Services means Dental Case Management and those benefits set forth in Welfare and Institutions Code Section 14132(h), 22 CCR 51059, and 51003.

Credentialing means the recognition of professional or technical competence. The process involved may include registration, certification, licensure and professional association membership.

Dental Records means written documentary evidence of dental treatments rendered to Contractor’s Members.

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

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

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

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

Eligible Beneficiary means any Medi-Cal beneficiary who is residing in the Contractor's Service Area and has met all the qualifications with one of the following aid codes:

Aid Group	Mandatory Aid Codes	Non-Mandatory Aid Codes
Family	01, 02, 08, 0A, 0G, 30, 32, 33, 34, 35, 38, 39, 3A, 3C, 3E, 3F, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 47, 54, 59, 5V, 72, 7A, 7L, 7S, 7W, 7X, 82, 8P, 8R, E6, E7, K1, L6, M7,	03, 04, 07, 40, 42, 43, 45, 49, 4A, 4E, 4F, 4G, 4H, 4K, 4L, 4M, 4N, 4S, 4T, 4W, 5K, 7J
Adult Expansion	7U, E2, E5, L1, M1, M3, M5, P5, P7, P9, T1, T2, T3, T4, T5	
Aged		06, 10, 14, 16, 46, 1E, 1H
Disabled		20, 24, 26, 2E, 2H, 36, 60, 64, 66, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6V
Adult		86
Child	5C, 5D, H1, H2, H3, H4, H5	
Breast and Cervical Cancer Treatment Program (BCCTP)		0N, 0P, 0W

Emergency Dental Condition means a dental condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of dentistry could reasonably expect the absence of immediate dental attention to result in:

- A. Placing the patient's health (or in the case of pregnant woman, the health of the woman or unborn child) in serious jeopardy, such as:
 - 1) High risk-to-life or seriously disabling conditions such as cellulitis, oral hemorrhage, and trauma.
 - 2) Low risk-to-life or minimally disabling conditions such as painful low-grade oral infections, near pulpal exposures, or fractured teeth.
- B. Serious impairment to bodily function.

- C. Serious dysfunction of any bodily organ or part.

Emergency Services means Covered Services that are furnished by a Provider that is qualified to furnish those services needed to evaluate or stabilize an Emergency Dental Condition.

Encounter means any single face-to-face dentally related service rendered by a dental Provider(s) to a Member enrolled in the plan during the date of service. It includes, but is not limited to, all services for which the Contractor incurred any financial liability.

Enrollee means a Medicaid beneficiary who is currently enrolled in an MCO, PIHP, PAHP, PCCM, or PCCM entity in a given managed care program.

Enrollee Encounter Data means the information relating to the receipt of any item(s) or service(s) by an enrollee under a contract between a State and a MCO, PIHP, or PAHP that is subject to the requirements of 42 CFR § 438.242 and 438.818.

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

Facility means any Service Location or premise that is:

- A. Owned, leased, used or operated directly or indirectly by or for the Contractor or its Affiliates for purposes related to this Contract, or
- B. Maintained by a Provider to provide services on behalf of the Contractor.

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

Federally Qualified Health Center (FQHC) means an entity defined in Section 1905 of the Social Security Act. (42 USC 1396d(l)(2)(B).)

Federally qualified HMO means an HMO that CMS has determined is a qualified HMO under section 1310(d) of the PHS Act. Fraud has the same meaning as the term is defined in 42 CFR § 455.2.

Fee-For-Service (FFS) means a method of payment based upon per unit or per procedure billing for services rendered to an Eligible Beneficiary.

Fee-For-Service Medi-Cal means the component of the Medi-Cal Program which Medi-Cal providers are paid directly by the State for services not covered under this Contract.

Financial Performance Guarantee means cash or cash equivalents which are immediately redeemable upon demand by DHCS, in an amount determined by DHCS, which shall not be less than one full month's capitation.

Financial Statements means the Financial Statements which include a Balance Sheet, Income Statement, Statement of Cash Flows, Statement of Equity and accompanying footnotes prepared in accordance with Generally Accepted Accounting Principles.

Fiscal Year (FY) means any 12-month period for which annual accounts are kept. The State Fiscal Year is July 1 through June 30; the federal Fiscal Year is October 1 through September 30.

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law (42 CFR 455.2; Welf. & Inst. Code §14043.1(i).)

Geographic Managed Care (GMC) Program means the Medi-Cal Dental GMC Program authorized by Section 14089 et seq. of the Welfare and Institutions Code.

Grievance means an oral or written expression of dissatisfaction, including any complaint, dispute, request for reconsideration, or appeal made by a Member. In the case of a Grievance that constitutes an “appeal” under 42 CFR 438.400(b), the provider must have the Member’s written consent before filing the Grievance on behalf of the Member.

Implementation Period means the timeframe from contract effective date to the beginning of the Operations period.

Indian Health Care Provider Service (IHGPS) Facilities means ~~Facilities operated with funds from the IHS under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area. (22 CCR 55000.)~~ a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603 & 42 CFR §§ 438.2, § 438.14.)

Knox-Keene Health Care Service Plan Act of 1975 means the law that regulates Health Maintenance Organizations (HMO) specialized health care (dental) plans and is administrated by the Department of Managed Health Care, commencing with Section 1340, Health and Safety Code.

Managed care organization (MCO) means an entity that has, or is seeking to qualify for, a comprehensive risk contract under this part and that is:

1. A Federally qualified HMO that meets the advance directives requirements of subpart I of part 489 of this chapter; or
2. Any public or private entity that meets the advance directives requirements and is determined by the Secretary to also meet the following conditions:
 - a) Makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the area served by the entity.

b) Meets the solvency standards of 42 CFR § 438.116.

Managed care program means a managed care delivery system operated by the State as authorized under sections 1915(a), 1915(b), 1932(a), or 1115(a) of the Act.

Material adjustment means an adjustment that, using reasonable actuarial judgment, has a significant impact on the development of the capitation payment such that its omission or misstatement could impact a determination whether the development of the capitation rate is consistent with generally accepted actuarial principles and practices.

Marketing means any activity conducted on behalf of the Contractor where information regarding the services offered by the Contractor is disseminated in order to persuade Eligible Beneficiaries to enroll. Marketing also includes any similar activity to secure the endorsement of any individual or organization on behalf of the Contractor.

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

Measurement Year means the timeframe beginning January 1st and continuing for twelve (12) months.

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

Medically Necessary Dental Covered Services means reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury. (22 CCR 51303(a), 51340, and 51340.1)

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

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

Network provider means any provider, group of providers, or entity that has a network provider agreement with a MCO, PIHP, or PAHP, or a subcontractor, and receives Medicaid funding directly or indirectly to order, refer or render covered services as a result of the state's contract with an MCO, PIHP, or PAHP. A network provider is not a subcontractor by virtue of the network provider agreement.

Nonrisk contract means a contract between the State and a PIHP or PAHP under which the contractor:

1. Is not at financial risk for changes in utilization or for costs incurred under the contract that do not exceed the upper payment limits specified in 42 CFR § 447.362; and
2. May be reimbursed by the State at the end of the contract period on the basis of the incurred costs, subject to the specified limits.

Newborn Child means a child born to a Member during her membership or the month prior to her membership.

Non-Medical Transportation means transportation of Members to dental services by passenger car, taxicabs, or other forms of public or private conveyances provided by persons **not** registered as Medi-Cal providers. Does not include the transportation of sick, injured, invalid, convalescent, infirm, or otherwise incapacitated Members by ambulances, litter vans, or wheelchair vans licensed, operated and equipped in accordance with State and local statutes, ordinances or regulations.

Operations Period means the period of time under this Contract that commences at the conclusion of the Implementation Period when the Contractor is responsible for the delivery of Covered Services to Members, and DHCS is responsible for payment for such Covered Services.

Other Healthcare Coverage (OHC) means coverage for dental related services or entitlements for which an Eligible Beneficiary is eligible under a private dental plan, any indemnification insurance program, any other State or federal dental care program, or under other contractual or legal entitlement. The responsibility of an individual or entity, other than Contractor or the Member, for the payment of the reasonable value of all or part of the dental benefits provided to a Member. This responsibility may result from a dental insurance policy or other contractual agreement or legal obligation, excluding tort liability.

Overpayment means any payment made to a network provider by a MCO, PIHP, or PAHP to which the network provider is not entitled to under Title XIX of the Act or any payment to a MCO, PIHP, or PAHP by a State to which the MCO, PIHP, or PAHP is not entitled to under 42 CFR § 438.2.

P Factor means the percentage of connected calls versus non-connected calls and/or busy signals.

Peer Review means a review by members of the profession regarding the quality of care provided a patient, including documentation of care (dental audit), diagnostic steps used, conclusions reached, treatment rendered, appropriateness of utilization (Utilization Review), and reasonableness of charged claims. The evaluation covers how well all dental personnel perform services and how appropriate the services are to meet the Member's needs.

Phaseout Period means the timeframe beginning with the end of Operations Period or contract extension through the following seven (7) months.

Physician Services means professional services performed by dentists, including surgery, consultation, and home, office, and institutional calls.

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

Post Stabilization Care Services means covered services, related to an emergency dental condition that are provided after an enrollee is stabilized in order to maintain the stabilized condition, or, to improve or resolve the enrollee's condition.

Potential Enrollee means a Medi-Cal beneficiary who is subject to mandatory enrollment or may voluntarily elect to enroll in a given MCO, PIHP, PAHP, PCCM or PCCM entity, but is not yet an enrollee of a specific MCO, PIHP, PAHP, PCCM, or PCCM entity. ~~recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific plan.~~

Prepaid Ambulatory Health Plan (PAHP) means an entity that—

- 1. Provides services to enrollees under contract with the State, and on the basis of capitation payments, or other payment arrangements that do not use State plan payment rates.**
- 2. Does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and**
- 3. Does not have a comprehensive risk contract.**

Prepaid Health Plan (PHP) Program means the Medi-Cal Dental Managed Care PHP program.

Prepaid Inpatient Health Plan (PIHP) means an entity that—

- 1. Provides services to enrollees under contract with the State, and on the basis of capitation payments, or other payment arrangements that do not use State plan payment rates.**
- 2. Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and,**
- 3. Does not have a comprehensive risk contract.**

Preventive Services means dental care designed to prevent dental disease and/or its consequences.

Primary Dental Care means a basic level of dental care usually rendered by general dentists and, in the case of certain children and adolescents, by pediatric dentists. This type of care emphasizes providing a Member's general dental care needs and typically involves ongoing, continuous care as distinguished from the dental care provided by Specialists.

Primary Care means all health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine

physician, obstetrician/gynecologist, pediatrician, or other licensed practitioner as authorized by the State Medicaid program, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them.

Primary Care Case Management means a system under which:

1. A primary care case manager (PCCM) contracts with the State to furnish case management services (which include the location, coordination and monitoring of primary health care services) to Medicaid beneficiaries; or
2. A PCCM entity contracts with the State to provide a defined set of functions

Primary Care Case Management Entity (PCCM entity) means an organization that provides any of the following functions, in addition to primary care case management services, for the State:

1. Provision of intensive telephonic or face-to-face case management, including operation of a nurse triage advice line.
2. Development of enrollee care plans.
3. Execution of contracts with and/or oversight responsibilities for the activities of FFS providers in the FFS program.
4. Provision of payments to FFS providers on behalf of the State.
5. Provision of Member outreach and education activities.
6. Operation of a customer service call center.
7. Review of provider claims, utilization and practice patterns to conduct provider profiling and/or practice improvement.
8. Implementation of quality improvement activities including administering Member satisfaction surveys or collecting data necessary for performance measurement of providers.
9. Coordination with behavioral health systems/providers
10. Coordination with long-term services and supports systems/providers

Primary Care Case Manager (PCCM) means a physician, a physician group practice or, at State option, any of the following:

1. A physician assistant.
2. A nurse practitioner.
3. A certified nurse-midwife

Primary Care Dentist (PCD) means a dentist licensed by and in good standing with the Dental Board of California and is responsible for supervising, coordinating, and providing initial and Primary Dental Care to Members, for initiating referrals, and for maintaining the continuity of dental care for the Member.

Prior Authorization means a formal process requiring a Provider to obtain advance approval to provide specific services or procedures.

Provider means a Primary Care Dentist, dentist, dental group, Subcontractor, Sub-subcontractor, or other individual or entity that renders Covered Services to a Member-, that is

engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the State in which it delivers the services.

Provider Grievance means an oral or written expression of dissatisfaction, including any complaint, dispute, and request for reconsideration or appeal made by a Provider. DHCS considers complaints and appeals the same as a grievance.

Quality Assurance (QA) means a formal set of activities to assure the quality of clinical and non-clinical services provided. Quality Assurance includes quality assessment and Corrective Actions taken to remedy any deficiencies identified through the assessment process. Comprehensive Quality Assurance includes mechanisms to assess and assure the quality of both dental services and administrative and support services.

Quality Improvement System (QIS) means the systematic activities to monitor and evaluate the dental care delivered to Members according to the standards set forth in regulations and Contract language. Contractor must have processes in place, which measure the effectiveness of care, identify problems, and implement improvement on a continuing basis.

Quality of Care means the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

Quality Indicators/Quality Measures/Performance Measures means measurable variables relating to a specific clinic or health services delivery area which are reviewed over a period of time to screen delivered health care and to monitor the process or outcome of care delivered in that clinical area.

Rate Cell means a set of mutually exclusive categories of enrollees that is defined by one or more characteristics for the purpose of determining the capitation rate and making a capitation payment; such characteristics may include age, gender, eligibility category, and region or geographic area. Each enrollee should be categorized in one of the rate cells for each unique set of mutually exclusive benefits under the contract.

Rating Period means a period of 12 months selected by the State for which the actuarially sound capitation rates are developed and documented in the rate certification submitted to CMS as required by 42 CFR § 438.7(a).

Risk Contract means a contract between the State an MCO, PIHP or PAHP under which the contractor—

- 1. Assumes risk for the cost of the services covered under the contract; and**
- 2. Incurs loss if the cost of furnishing the services exceeds the payments under the contract.**

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

Seniors and Persons with Disabilities mean Medi-Cal beneficiaries eligible for benefits through blindness, age or disability, in accordance with 42 USC § 1381 et. seq.

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

Service Location means any location or Facility at which a Member obtains any Covered Services rendered by a Provider under the terms of this Contract.

Specialist means any dentist whose practice is directed at highly specialized dental procedures where certification is either required or encouraged by the dental community. Generally, such dentist would derive their patients from a referring Primary Care Dentist and would not maintain an on-going relationship with the patient beyond the course of treatment required by the referral.

State means the State of California.

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

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

Subcontractor means an individual or in many cases a business that signs a contract to perform part or all of the obligations of another's contract. **In addition, the individual or entity that has a contract with Contractor that relates directly or indirectly to the performance of the Contractor's obligations under its contract with the State. A network provider is not a subcontractor by virtue of the network provider agreement with the Contractor.**

State means the Single State agency as specified in 42 CFR § 431.10.

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

Targeted Low-Income Child means a plan Member whose presumptive eligibility determination for Medi-Cal places them in transitory aid codes 5C or 5D, or whose Medi-Cal eligibility places them in aid codes H1, H2, H3, H4, or H5.

Third Party Tort Liability (TPTL) means the responsibility of an individual or entity other than Contractor or the Member for the payment of claims for injuries or trauma sustained by a Member. This responsibility may be contractual, a legal obligation, or as a result of, or the fault or negligence of, third parties (e.g., auto accidents or other personal injury casualty claims or Workers' Compensation appeals).

Utilization Review means the process of evaluating the necessity, appropriateness, and efficiency of the use of dental services, procedures and Facilities.

**EXHIBIT E, ATTACHMENT 2
DUTIES OF THE STATE****A. Payment for Services**

Pursuant to Exhibit B, Budget Detail and Payment, Provision C, Capitation Payment, the DHCS shall pay to the Contractor capitation payments for each eligible Member under this contract. DHCS shall ensure that payments are based on actuarially sound capitation rates as defined in 42 CFR, 438.6(c).

B. Dental and Other Reviews

DHCS shall conduct reviews in accordance with the provisions of Welfare and Institutions (W&I) Code sections 14456 and 14457. In accordance with W&I Code section 14556, DHCS shall have the discretion to accept plan performance reports, audits or reviews conducted by other agencies or accrediting bodies that use standards comparable to those of DHCS. In an effort to eliminate duplication of auditing efforts, these plan performance reports, audits and reviews may be in lieu of an audit or review conducted by DHCS.

C. Enrollment

DHCS' Medi-Cal managed care system is to improve quality and access to care for Medi-Cal beneficiaries. For the purpose of this contract, the DHCS and the Contractor acknowledge that the Medi-Cal eligibility process and the managed care enrollment system are dynamic and complex programs. DHCS shall cooperatively work with the Contractor to ensure that Eligible Beneficiaries who choose to or should be assigned to Contractor's plan are enrolled in Contractor's plan pursuant to the requirements of Exhibit E, Attachment 2, Provision D, Enrollment and Disenrollment Processing. The DHCS agrees that to accomplish this goal it is necessary to be reasonably flexible with regard to the enrollment process.

D. Enrollment and Disenrollment Processing**1. DHCS Enrollment Obligations**

- a. DHCS shall receive applications for enrollment from its Enrollment Contractor. DHCS shall verify the current eligibility of applicants for enrollment in Contractor's plan under this contract. If the Contractor has the capacity to accept new Members, DHCS or its Enrollment Contractor shall enroll Eligible Beneficiaries in the Contractor's plan when selected by the Eligible Beneficiary. The Beneficiary will receive an effective date of plan enrollment that is no later than ninety (90) calendar days from the date that the Medi-Cal Eligibility Data System identifies the Beneficiary as satisfying the enrollment criteria. DHCS shall provide the Contractor a list of Members on a monthly basis and no later than the 10th calendar day of each month.

2. Enrollment Competition

Notwithstanding any provision in this contract or law, the DHCS shall ensure that Eligible Beneficiaries have a choice of competing dental plans in the Geographic Managed Care program. DHCS makes no representations or guarantees relating to the number of Eligible Beneficiaries who may choose to be enrolled in Contractor's plan. DHCS shall not be liable for any lack of Eligible Beneficiary Enrollment in Contractor's plan.

3. Disenrollment Processing

DHCS, or its Enrollment Contractor, shall review and process requests for disenrollment and notify the Contractor and the Member of its decision.

E. Approval Process for Submitted Materials during Operations

For materials required to be submitted during the Operations Period of this contract, DHCS shall make all reasonable efforts to review such materials within forty-five (45) calendar days of receipt. At the conclusion of the review, DHCS will provide written notification to the Contractor identifying whether the materials are approved or denied. If the materials are denied, DHCS shall provide a written explanation as to why the materials were not approved.

Absent the DHCS' written approval of submitted material, the Contractor may be subject to sanctions for the publication of any unapproved material. This Provision shall not apply to subcontracts or sub-subcontracts subject to DHCS approval in accordance with Exhibit A, Attachment 8, Provider Network, Provision J, Subsection 2.

F. Risk Limitation

Except as provided in Exhibit B, Budget Detail and Payment, Provision J, the DHCS shall ensure that this Contract shall be free of any risk limitation, and the Contractor shall have full financial liability to provide medically necessary dental covered services to its Members.

G. Member Notification

DHCS shall notify Members of their dental care benefits and options available upon termination or expiration of this contract.

Contractor's Release

Instructions to Contractor:

With final invoice(s) submit one (1) original and one (1) copy. The original must bear the original signature of a person authorized to bind the Contractor. The additional copy may bear photocopied signatures.

Submission of Final Invoice

Pursuant to **contract number** _____ entered into between the Department of Health Care Services (DHCS) and the Contractor (identified below), the Contractor does acknowledge that final payment has been requested via **invoice number(s)** _____, in the **amount(s) of \$** _____ and **dated** _____.
If necessary, enter "See Attached" in the appropriate blocks and attach a list of invoice numbers, dollar amounts and invoice dates.

Release of all Obligations

By signing this form, and upon receipt of the amount specified in the invoice number(s) referenced above, the Contractor does hereby release and discharge the State, its officers, agents and employees of and from any and all liabilities, obligations, claims, and demands whatsoever arising from the above referenced contract.

Repayments Due to Audit Exceptions / Record Retention

By signing this form, Contractor acknowledges that expenses authorized for reimbursement does not guarantee final allowability of said expenses. Contractor agrees that the amount of any sustained audit exceptions resulting from any subsequent audit made after final payment will be refunded to the State.

All expense and accounting records related to the above referenced contract must be maintained for audit purposes for no less than three years beyond the date of final payment, unless a longer term is stated in said contract.

Recycled Product Use Certification

By signing this form, Contractor certifies under penalty of perjury that a minimum of 0% unless otherwise specified in writing of post consumer material, as defined in the Public Contract Code Section 12200, in products, materials, goods, or supplies offered or sold to the State regardless of whether it meets the requirements of Public Contract Code Section 12209. Contractor specifies that printer or duplication cartridges offered or sold to the State comply with the requirements of Section 12156(e).

Reminder to Return State Equipment/Property (If Applicable)

(Applies only if equipment was provided by DHCS or purchased with or reimbursed by contract funds)

Unless DHCS has approved the continued use and possession of State equipment (as defined in the above referenced contract) for use in connection with another DHCS agreement, Contractor agrees to promptly initiate arrangements to account for and return said equipment to DHCS, at DHCS' expense, if said equipment has not passed its useful life expectancy as defined in the above referenced contract.

Patents / Other Issues

By signing this form, Contractor further agrees, in connection with patent matters and with any claims that are not specifically released as set forth above, that it will comply with all of the provisions contained in the above referenced contract, including, but not limited to, those provisions relating to notification to the State and related to the defense or prosecution of litigation.

ONLY SIGN AND DATE THIS DOCUMENT WHEN ATTACHING IT TO THE FINAL INVOICE

Contractor's Legal Name (as on contract): _____

Signature of Contractor or Official Designee: _____ Date: _____

Printed Name/Title of Person Signing: _____

Distribution: Accounting (Original) Program

Health Insurance Portability and Accountability Act (HIPAA) Business Associate Addendum

Exhibit G

Health Insurance Portability and Accountability Act (HIPAA) Business Associate Addendum

I. Recitals

- A. This Contract (Agreement) has been determined to constitute a business associate relationship under the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("the HITECH Act"), 42 U.S.C. section 17921 et seq., and their implementing privacy and security regulations at 45 CFR Parts 160 and 164 ("the HIPAA regulations").
- B. The Department of Health Care Services ("DHCS") wishes to disclose to Business Associate certain information pursuant to the terms of this Agreement, some of which may constitute Protected Health Information ("PHI"), including protected health information in electronic media ("ePHI"), under federal law, and personal information ("PI") under state law.
- C. As set forth in this Agreement, Contractor, here and after, is the Business Associate of DHCS acting on DHCS' behalf and provides services, arranges, performs or assists in the performance of functions or activities on behalf of DHCS and creates, receives, maintains, transmits, uses or discloses PHI and PI. DHCS and Business Associate are each a party to this Agreement and are collectively referred to as the "parties."
- D. The purpose of this Addendum is to protect the privacy and security of the PHI and PI that may be created, received, maintained, transmitted, used or disclosed pursuant to this Agreement, and to comply with certain standards and requirements of HIPAA, the HITECH Act and the HIPAA regulations, including, but not limited to, the requirement that DHCS must enter into a contract containing specific requirements with Contractor prior to the disclosure of PHI to Contractor, as set forth in 45 CFR Parts 160 and 164 and the HITECH Act, and the Final Omnibus Rule as well as the Alcohol and Drug Abuse patient records confidentiality law 42 CFR Part 2, and any other applicable state or federal law or regulation. 42 CFR section 2.1(b)(2)(B) allows for the disclosure of such records to qualified personnel for the purpose of conducting management or financial audits, or program evaluation. 42 CFR Section 2.53(d) provides that patient identifying information disclosed under this section may be disclosed only back to the program from which it was obtained and used only to carry out an audit or evaluation purpose or to investigate or prosecute criminal or other activities, as authorized by an appropriate court order.
- E. The terms used in this Addendum, but not otherwise defined, shall have the same meanings as those terms have in the HIPAA regulations. Any reference to statutory or regulatory language shall be to such language as in effect or as amended.

II. Definitions

- A. Breach shall have the meaning given to such term under HIPAA, the HITECH Act, the HIPAA regulations, and the Final Omnibus Rule.
- B. Business Associate shall have the meaning given to such term under HIPAA, the HITECH Act, the HIPAA regulations, and the final Omnibus Rule.
- C. Covered Entity shall have the meaning given to such term under HIPAA, the HITECH Act, the HIPAA regulations, and Final Omnibus Rule.
- D. Electronic Health Record shall have the meaning given to such term in the HITECH Act, including, but not limited to, 42 U.S.C Section 17921 and implementing regulations.

Health Insurance Portability and Accountability Act (HIPAA) Business Associate Addendum

- E. Electronic Protected Health Information (ePHI) means individually identifiable health information transmitted by electronic media or maintained in electronic media, including but not limited to electronic media as set forth under 45 CFR section 160.103.
- F. Individually Identifiable Health Information means health information, including demographic information collected from an individual, that is created or received by a health care provider, health plan, employer or health care clearinghouse, and relates to the past, present or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, that identifies the individual or where there is a reasonable basis to believe the information can be used to identify the individual, as set forth under 45 CFR section 160.103.
- G. Privacy Rule shall mean the HIPAA Regulation that is found at 45 CFR Parts 160 and 164.
- H. Personal Information shall have the meaning given to such term in California Civil Code section 1798.29.
- I. Protected Health Information means individually identifiable health information that is transmitted by electronic media, maintained in electronic media, or is transmitted or maintained in any other form or medium, as set forth under 45 CFR section 160.103.
- J. Required by law, as set forth under 45 CFR section 164.103, means a mandate contained in law that compels an entity to make a use or disclosure of PHI that is enforceable in a court of law. This includes, but is not limited to, court orders and court-ordered warrants, subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or an administrative body authorized to require the production of information, and a civil or an authorized investigative demand. It also includes Medicare conditions of participation with respect to health care providers participating in the program, and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits.
- K. Secretary means the Secretary of the U.S. Department of Health and Human Services ("HHS") or the Secretary's designee.
- L. Security Incident means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of PHI or PI, or confidential data that is essential to the ongoing operation of the Business Associate's organization and intended for internal use; or interference with system operations in an information system.
- M. Security Rule shall mean the HIPAA regulation that is found at 45 CFR Parts 160 and 164.
- N. Unsecured PHI shall have the meaning given to such term under the HITECH Act, 42 U.S.C. section 17932(h), any guidance issued pursuant to such Act, and the HIPAA regulations.

III. Terms of Agreement**A. Permitted Uses and Disclosures of PHI by Business Associate**

Permitted Uses and Disclosures. Except as otherwise indicated in this Addendum, Business Associate may use or disclose PHI only to perform functions, activities or services specified in this Agreement, for, or on behalf of DHCS, provided that such use or disclosure would not violate the HIPAA regulations, if done by DHCS. Any such use or disclosure must, to the extent practicable, be limited to the limited data set, as defined in 45 CFR section 164.514(e)(2), or, if needed, to the minimum necessary to accomplish

Health Insurance Portability and Accountability Act (HIPAA) Business Associate Addendum

the intended purpose of such use or disclosure, in compliance with the HITECH Act and any guidance issued pursuant to such Act, the HIPAA regulations, the Final Omnibus Rule and 42 CFR Part 2.

1. ***Specific Use and Disclosure Provisions.*** Except as otherwise indicated in this Addendum, Business Associate may:
 - a. ***Use and disclose for management and administration.*** Use and disclose PHI for the proper management and administration of the Business Associate provided that such disclosures are required by law, or the Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and will be used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware that the confidentiality of the information has been breached.
 - b. ***Provision of Data Aggregation Services.*** Use PHI to provide data aggregation services to DHCS. Data aggregation means the combining of PHI created or received by the Business Associate on behalf of DHCS with PHI received by the Business Associate in its capacity as the Business Associate of another covered entity, to permit data analyses that relate to the health care operations of DHCS.

B. Prohibited Uses and Disclosures

1. Business Associate shall not disclose PHI about an individual to a health plan for payment or health care operations purposes if the PHI pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full and the individual requests such restriction, in accordance with 42 U.S.C. section 17935(a) and 45 CFR section 164.522(a).
2. Business Associate shall not directly or indirectly receive remuneration in exchange for PHI, except with the prior written consent of DHCS and as permitted by 42 U.S.C. section 17935(d)(2).

C. Responsibilities of Business Associate

Business Associate agrees:

1. ***Nondisclosure.*** Not to use or disclose Protected Health Information (PHI) other than as permitted or required by this Agreement or as required by law.
2. ***Safeguards.*** To implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI, including electronic PHI, that it creates, receives, maintains, uses or transmits on behalf of DHCS, in compliance with 45 CFR sections 164.308, 164.310 and 164.312, and to prevent use or disclosure of PHI other than as provided for by this Agreement. Business Associate shall implement reasonable and appropriate policies and procedures to comply with the standards, implementation specifications and other requirements of 45 CFR section 164, subpart C, in compliance with 45 CFR section 164.316. Business Associate shall develop and maintain a written information privacy and security program that includes administrative, technical and physical safeguards appropriate to the size and complexity of the Business Associate's operations and the nature and scope of its activities, and which incorporates the requirements of section 3, Security, below. Business Associate will provide DHCS with its current and updated policies.

Health Insurance Portability and Accountability Act (HIPAA) Business Associate Addendum

3. **Security.** To take any and all steps necessary to ensure the continuous security of all computerized data systems containing PHI and/or PI, and to protect paper documents containing PHI and/or PI. These steps shall include, at a minimum:
- a. Complying with all of the data system security precautions listed in Attachment A, the Business Associate Data Security Requirements;
 - b. Achieving and maintaining compliance with the HIPAA Security Rule (45 CFR Parts 160 and 164), as necessary in conducting operations on behalf of DHCS under this Agreement;
 - c. Providing a level and scope of security that is at least comparable to the level and scope of security established by the Office of Management and Budget in OMB Circular No. A-130, Appendix III - Security of Federal Automated Information Systems, which sets forth guidelines for automated information systems in Federal agencies; and
 - d. In case of a conflict between any of the security standards contained in any of these enumerated sources of security standards, the most stringent shall apply. The most stringent means that safeguard which provides the highest level of protection to PHI from unauthorized disclosure. Further, Business Associate must comply with changes to these standards that occur after the effective date of this Agreement.

Business Associate shall designate a Security Officer to oversee its data security program who shall be responsible for carrying out the requirements of this section and for communicating on security matters with DHCS.

- D. Mitigation of Harmful Effects.** To mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate or its subcontractors in violation of the requirements of this Addendum.

E. Business Associate's Agents and Subcontractors.

- 1. To enter into written agreements with any agents, including subcontractors and vendors, to whom Business Associate provides PHI or PI received from or created or received by Business Associate on behalf of DHCS, that impose the same restrictions and conditions on such agents, subcontractors and vendors that apply to Business Associate with respect to such PHI and PI under this Addendum, and that comply with all applicable provisions of HIPAA, the HITECH Act the HIPAA regulations, and the Final Omnibus Rule, including the requirement that any agents, subcontractors or vendors implement reasonable and appropriate administrative, physical, and technical safeguards to protect such PHI and PI. Business associates are directly liable under the HIPAA Rules and subject to civil and, in some cases, criminal penalties for making uses and disclosures of protected health information that are not authorized by its contract or required by law. A business associate also is directly liable and subject to civil penalties for failing to safeguard electronic protected health information in accordance with the HIPAA Security Rule. A "business associate" also is a subcontractor that creates, receives, maintains, or transmits protected health information on behalf of another business associate. Business Associate shall incorporate, when applicable, the relevant provisions of this Addendum into each subcontract or subaward to such agents, subcontractors and vendors, including the requirement that any security incidents or breaches of unsecured PHI or PI be reported to Business Associate.
- 2. In accordance with 45 CFR section 164.504(e)(1)(ii), upon Business Associate's knowledge of a material breach or violation by its subcontractor of the agreement between Business Associate and the subcontractor, Business Associate shall:

Health Insurance Portability and Accountability Act (HIPAA) Business Associate Addendum

- a. Provide an opportunity for the subcontractor to cure the breach or end the violation and terminate the agreement if the subcontractor does not cure the breach or end the violation within the time specified by DHCS; or
- b. Immediately terminate the agreement if the subcontractor has breached a material term of the agreement and cure is not possible.

F. Availability of Information to DHCS and Individuals. To provide access and information:

1. To provide access as DHCS may require, and in the time and manner designated by DHCS (upon reasonable notice and during Business Associate's normal business hours) to PHI in a Designated Record Set, to DHCS (or, as directed by DHCS), to an Individual, in accordance with 45 CFR section 164.524. Designated Record Set means the group of records maintained for DHCS that includes medical, dental and billing records about individuals; enrollment, payment, claims adjudication, and case or medical management systems maintained for DHCS health plans; or those records used to make decisions about individuals on behalf of DHCS. Business Associate shall use the forms and processes developed by DHCS for this purpose and shall respond to requests for access to records transmitted by DHCS within fifteen (15) calendar days of receipt of the request by producing the records or verifying that there are none.
2. If Business Associate maintains an Electronic Health Record with PHI, and an individual requests a copy of such information in an electronic format, Business Associate shall provide such information in an electronic format to enable DHCS to fulfill its obligations under the HITECH Act, including but not limited to, 42 U.S.C. section 17935(e).
3. If Business Associate receives data from DHCS that was provided to DHCS by the Social Security Administration, upon request by DHCS, Business Associate shall provide DHCS with a list of all employees, contractors and agents who have access to the Social Security data, including employees, contractors and agents of its subcontractors and agents.

G. Amendment of PHI. To make any amendment(s) to PHI that DHCS directs or agrees to pursuant to 45 CFR section 164.526, in the time and manner designated by DHCS.**H. Internal Practices.** To make Business Associate's internal practices, books and records relating to the use and disclosure of PHI received from DHCS, or created or received by Business Associate on behalf of DHCS, available to DHCS or to the Secretary of the U.S. Department of Health and Human Services in a time and manner designated by DHCS or by the Secretary, for purposes of determining DHCS' compliance with the HIPAA regulations. If any information needed for this purpose is in the exclusive possession of any other entity or person and the other entity or person fails or refuses to furnish the information to Business Associate, Business Associate shall so certify to DHCS and shall set forth the efforts it made to obtain the information.

Health Insurance Portability and Accountability Act (HIPAA) Business Associate Addendum

I. **Documentation of Disclosures.** To document and make available to DHCS or (at the direction of DHCS) to an Individual such disclosures of PHI, and information related to such disclosures, necessary to respond to a proper request by the subject Individual for an accounting of disclosures of PHI, in accordance with the HITECH Act and its implementing regulations, including but not limited to 45 CFR section 164.528 and 42 U.S.C. section 17935(c). If Business Associate maintains electronic health records for DHCS as of January 1, 2009, Business Associate must provide an accounting of disclosures, including those disclosures for treatment, payment or health care operations, effective with disclosures on or after January 1, 2014. If Business Associate acquires electronic health records for DHCS after January 1, 2009, Business Associate must provide an accounting of disclosures, including those disclosures for treatment, payment or health care operations, effective with disclosures on or after the date the electronic health record is acquired, or on or after January 1, 2011, whichever date is later. The electronic accounting of disclosures shall be for disclosures during the three years prior to the request for an accounting.

J. **Breaches and Security Incidents.** During the term of this Agreement, Business Associate agrees to implement reasonable systems for the discovery and prompt reporting of any breach or security incident, and to take the following steps:

1. **Notice to DHCS.** (1) To notify DHCS **immediately** upon the discovery of a suspected security incident that involves data provided to DHCS by the Social Security Administration. This notification will be **by telephone call plus email or fax** upon the discovery of the breach. (2) To notify DHCS **within 24 hours by email or fax** of the discovery of unsecured PHI or PI in electronic media or in any other media if the PHI or PI was, or is reasonably believed to have been, accessed or acquired by an unauthorized person, any suspected security incident, intrusion or unauthorized access, use or disclosure of PHI or PI in violation of this Agreement and this Addendum, or potential loss of confidential data affecting this Agreement. A breach shall be treated as discovered by Business Associate as of the first day on which the breach is known, or by exercising reasonable diligence would have been known, to any person (other than the person committing the breach) who is an employee, officer or other agent of Business Associate.

Notice shall be provided to the DHCS Program Contract Manager, the DHCS Privacy Officer and the DHCS Information Security Officer. If the incident occurs after business hours or on a weekend or holiday and involves data provided to DHCS by the Social Security Administration, notice shall be provided by calling the DHCS EITS Service Desk. Notice shall be made using the "DHCS Privacy Incident Report" form, including all information known at the time. Business Associate shall use the most current version of this form, which is posted on the DHCS Privacy Office website (www.dhcs.ca.gov, then select "Privacy" in the left column and then "Business Use" near the middle of the page) or use this link:

<http://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/DHCSBusinessAssociatesOnly.aspx>

Upon discovery of a breach or suspected security incident, intrusion or unauthorized access, use or disclosure of PHI or PI, Business Associate shall take:

- a. Prompt corrective action to mitigate any risks or damages involved with the breach and to protect the operating environment; and
- b. Any action pertaining to such unauthorized disclosure required by applicable Federal and State laws and regulations.

Health Insurance Portability and Accountability Act (HIPAA) Business Associate Addendum

2. **Investigation and Investigation Report.** To immediately investigate such security incident, breach, or unauthorized access, use or disclosure of PHI or PI. If the initial report did not include all of the requested information marked with an asterisk, then within 72 hours of the discovery, Business Associate shall submit an updated "DHCS Privacy Incident Report" containing the information marked with an asterisk and all other applicable information listed on the form, to the extent known at that time, to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer:
3. **Complete Report.** To provide a complete report of the investigation to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer within ten (10) working days of the discovery of the breach or unauthorized use or disclosure. If all of the required information was not included in either the initial report, or the Investigation Report, then a separate Complete Report must be submitted. The report shall be submitted on the "DHCS Privacy Incident Report" form and shall include an assessment of all known factors relevant to a determination of whether a breach occurred under applicable provisions of HIPAA, the HITECH Act, the HIPAA regulations and/or state law. The report shall also include a full, detailed corrective action plan, including information on measures that were taken to halt and/or contain the improper use or disclosure. If DHCS requests information in addition to that listed on the "DHCS Privacy Incident Report" form, Business Associate shall make reasonable efforts to provide DHCS with such information. If necessary, a Supplemental Report may be used to submit revised or additional information after the completed report is submitted, by submitting the revised or additional information on an updated "DHCS Privacy Incident Report" form. DHCS will review and approve or disapprove the determination of whether a breach occurred, is reportable to the appropriate entities, if individual notifications are required, and the corrective action plan.
4. **Notification of Individuals.** If the cause of a breach of PHI or PI is attributable to Business Associate or its subcontractors, agents or vendors, Business Associate shall notify individuals of the breach or unauthorized use or disclosure when notification is required under state or federal law and shall pay any costs of such notifications, as well as any costs associated with the breach. The notifications shall comply with the requirements set forth in 42 U.S.C. section 17932 and its implementing regulations, including, but not limited to, the requirement that the notifications be made without unreasonable delay and in no event later than 60 calendar days. The DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer shall approve the time, manner and content of any such notifications and their review and approval must be obtained before the notifications are made.
5. **Responsibility for Reporting of Breaches.** If the cause of a breach of PHI or PI is attributable to Business Associate or its agents, subcontractors or vendors, Business Associate is responsible for all required reporting of the breach as specified in 42 U.S.C. section 17932 and its implementing regulations, including notification to media outlets and to the Secretary. If a breach of unsecured PHI involves more than 500 residents of the State of California or its jurisdiction, Business Associate shall notify the Secretary of the breach immediately upon discovery of the breach. If Business Associate has reason to believe that duplicate reporting of the same breach or incident may occur because its subcontractors, agents or vendors may report the breach or incident to DHCS in addition to Business Associate, Business Associate shall notify DHCS, and DHCS and Business Associate may take appropriate action to prevent duplicate reporting. The breach reporting requirements of this paragraph are in addition to the reporting requirements set forth in subsection 1, above.
6. **DHCS Contact Information.** To direct communications to the above referenced DHCS staff, the Contractor shall initiate contact as indicated herein. DHCS reserves the right to make changes to the

Health Insurance Portability and Accountability Act (HIPAA) Business Associate Addendum

contact information below by giving written notice to the Contractor. Said changes shall not require an amendment to this Addendum or the Agreement to which it is incorporated.

DHCS Program Contract Manager	DHCS Privacy Officer	DHCS Information Security Officer
See the Scope of Work exhibit for Program Contract Manager information	Privacy Officer c/o: Office of HIPAA Compliance Department of Health Care Services P.O. Box 997413, MS 4722 Sacramento, CA 95899-7413 Email: privacyofficer@dhcs.ca.gov Telephone: (916) 445-4646 Fax: (916) 440-7680	Information Security Officer DHCS Information Security Office P.O. Box 997413, MS 6400 Sacramento, CA 95899-7413 Email: iso@dhcs.ca.gov Fax: (916) 440-5537 Telephone: EITS Service Desk (916) 440-7000 or (800) 579-0874

K. Termination of Agreement. In accordance with Section 13404(b) of the HITECH Act and to the extent required by the HIPAA regulations, if Business Associate knows of a material breach or violation by DHCS of this Addendum, it shall take the following steps:

1. Provide an opportunity for DHCS to cure the breach or end the violation and terminate the Agreement if DHCS does not cure the breach or end the violation within the time specified by Business Associate; or
2. Immediately terminate the Agreement if DHCS has breached a material term of the Addendum and cure is not possible.

L. Due Diligence. Business Associate shall exercise due diligence and shall take reasonable steps to ensure that it remains in compliance with this Addendum and is in compliance with applicable provisions of HIPAA, the HITECH Act and the HIPAA regulations, and that its agents, subcontractors and vendors are in compliance with their obligations as required by this Addendum.

M. Sanctions and/or Penalties. Business Associate understands that a failure to comply with the provisions of HIPAA, the HITECH Act and the HIPAA regulations that are applicable to Business Associate may result in the imposition of sanctions and/or penalties on Business Associate under HIPAA, the HITECH Act and the HIPAA regulations.

IV. Obligations of DHCS

DHCS agrees to:

A. Notice of Privacy Practices. Provide Business Associate with the Notice of Privacy Practices that DHCS produces in accordance with 45 CFR section 164.520, as well as any changes to such notice. Visit the DHCS Privacy Office to view the most current Notice of Privacy Practices at: <http://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/default.aspx> or the DHCS website at www.dhcs.ca.gov (select "Privacy in the left column and "Notice of Privacy Practices" on the right side of the page).

B. Permission by Individuals for Use and Disclosure of PHI. Provide the Business Associate with any changes in, or revocation of, permission by an Individual to use or disclose PHI, if such changes affect the Business Associate's permitted or required uses and disclosures.

Health Insurance Portability and Accountability Act (HIPAA) Business Associate Addendum

- C. *Notification of Restrictions.*** Notify the Business Associate of any restriction to the use or disclosure of PHI that DHCS has agreed to in accordance with 45 CFR section 164.522, to the extent that such restriction may affect the Business Associate's use or disclosure of PHI.
- D. *Requests Conflicting with HIPAA Rules.*** Not request the Business Associate to use or disclose PHI in any manner that would not be permissible under the HIPAA regulations if done by DHCS.

V. Audits, Inspection and Enforcement

- A.** From time to time, DHCS may inspect the facilities, systems, books and records of Business Associate to monitor compliance with this Agreement and this Addendum. Business Associate shall promptly remedy any violation of any provision of this Addendum and shall certify the same to the DHCS Privacy Officer in writing. The fact that DHCS inspects, or fails to inspect, or has the right to inspect, Business Associate's facilities, systems and procedures does not relieve Business Associate of its responsibility to comply with this Addendum, nor does DHCS':
1. Failure to detect or
 2. Detection, but failure to notify Business Associate or require Business Associate's remediation of any unsatisfactory practices constitute acceptance of such practice or a waiver of DHCS' enforcement rights under this Agreement and this Addendum.
- B.** If Business Associate is the subject of an audit, compliance review, or complaint investigation by the Secretary or the Office of Civil Rights, U.S. Department of Health and Human Services, that is related to the performance of its obligations pursuant to this HIPAA Business Associate Addendum, Business Associate shall notify DHCS and provide DHCS with a copy of any PHI or PI that Business Associate provides to the Secretary or the Office of Civil Rights concurrently with providing such PHI or PI to the Secretary. Business Associate is responsible for any civil penalties assessed due to an audit or investigation of Business Associate, in accordance with 42 U.S.C. section 17934(c).

VI. Termination

- A. *Term.*** The Term of this Addendum shall commence as of the effective date of this Addendum and shall extend beyond the termination of the contract and shall terminate when all the PHI provided by DHCS to Business Associate, or created or received by Business Associate on behalf of DHCS, is destroyed or returned to DHCS, in accordance with 45 CFR 164.504(e)(2)(ii)(I).
- B. *Termination for Cause.*** In accordance with 45 CFR section 164.504(e)(1)(ii), upon DHCS' knowledge of a material breach or violation of this Addendum by Business Associate, DHCS shall:
1. Provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Agreement if Business Associate does not cure the breach or end the violation within the time specified by DHCS; or
 2. Immediately terminate this Agreement if Business Associate has breached a material term of this Addendum and cure is not possible.

Health Insurance Portability and Accountability Act (HIPAA) Business Associate Addendum

- C. *Judicial or Administrative Proceedings.*** Business Associate will notify DHCS if it is named as a defendant in a criminal proceeding for a violation of HIPAA. DHCS may terminate this Agreement if Business Associate is found guilty of a criminal violation of HIPAA. DHCS may terminate this Agreement if a finding or stipulation that the Business Associate has violated any standard or requirement of HIPAA, or other security or privacy laws is made in any administrative or civil proceeding in which the Business Associate is a party or has been joined.
- D. *Effect of Termination.*** Upon termination or expiration of this Agreement for any reason, Business Associate shall return or destroy all PHI received from DHCS (or created or received by Business Associate on behalf of DHCS) that Business Associate still maintains in any form, and shall retain no copies of such PHI. If return or destruction is not feasible, Business Associate shall notify DHCS of the conditions that make the return or destruction infeasible, and DHCS and Business Associate shall determine the terms and conditions under which Business Associate may retain the PHI. Business Associate shall continue to extend the protections of this Addendum to such PHI, and shall limit further use of such PHI to those purposes that make the return or destruction of such PHI infeasible. This provision shall apply to PHI that is in the possession of subcontractors or agents of Business Associate.

VII. Miscellaneous Provisions

- A. *Disclaimer.*** DHCS makes no warranty or representation that compliance by Business Associate with this Addendum, HIPAA or the HIPAA regulations will be adequate or satisfactory for Business Associate's own purposes or that any information in Business Associate's possession or control, or transmitted or received by Business Associate, is or will be secure from unauthorized use or disclosure. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI.
- B. *Amendment.*** The parties acknowledge that federal and state laws relating to electronic data security and privacy are rapidly evolving and that amendment of this Addendum may be required to provide for procedures to ensure compliance with such developments. The parties specifically agree to take such action as is necessary to implement the standards and requirements of HIPAA, the HITECH Act, the HIPAA regulations and other applicable laws relating to the security or privacy of PHI. Upon DHCS' request, Business Associate agrees to promptly enter into negotiations with DHCS concerning an amendment to this Addendum embodying written assurances consistent with the standards and requirements of HIPAA, the HITECH Act, the HIPAA regulations or other applicable laws. DHCS may terminate this Agreement upon thirty (30) days written notice in the event:
1. Business Associate does not promptly enter into negotiations to amend this Addendum when requested by DHCS pursuant to this Section; or
 2. Business Associate does not enter into an amendment providing assurances regarding the safeguarding of PHI that DHCS in its sole discretion, deems sufficient to satisfy the standards and requirements of HIPAA and the HIPAA regulations.
- C. *Assistance in Litigation or Administrative Proceedings.*** Business Associate shall make itself and any subcontractors, employees or agents assisting Business Associate in the performance of its obligations under this Agreement, available to DHCS at no cost to DHCS to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against DHCS, its directors, officers or employees based upon claimed violation of HIPAA, the HIPAA regulations or other laws relating to security and privacy, which involves inactions or actions by the Business Associate, except where Business Associate or its subcontractor, employee or agent is a named adverse party.

Health Insurance Portability and Accountability Act (HIPAA) Business Associate Addendum

- 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.

Health Insurance Portability and Accountability Act (HIPAA) Business Associate Addendum

Attachment A Business Associate Data Security Requirements

I. Personnel Controls

- A. *Employee Training.*** All workforce members who assist in the performance of functions or activities on behalf of DHCS, or access or disclose DHCS PHI or PI must complete information privacy and security training, at least annually, at Business Associate's expense. Each workforce member who receives information privacy and security training must sign a certification, indicating the member's name and the date on which the training was completed. These certifications must be retained for a period of six (6) years following contract termination.
- B. *Employee Discipline.*** Appropriate sanctions must be applied against workforce members who fail to comply with privacy policies and procedures or any provisions of these requirements, including termination of employment where appropriate.
- C. *Confidentiality Statement.*** All persons that will be working with DHCS PHI or PI must sign a confidentiality statement that includes, at a minimum, General Use, Security and Privacy Safeguards, Unacceptable Use, and Enforcement Policies. The statement must be signed by the workforce member prior to access to DHCS PHI or PI. The statement must be renewed annually. The Contractor shall retain each person's written confidentiality statement for DHCS inspection for a period of six (6) years following contract termination.
- D. *Background Check.*** Before a member of the workforce may access DHCS PHI or PI, a thorough background check of that worker must be conducted, with evaluation of the results to assure that there is no indication that the worker may present a risk to the security or integrity of confidential data or a risk for theft or misuse of confidential data. The Contractor shall retain each workforce member's background check documentation for a period of three (3) years following contract termination.

II. Technical Security Controls

- A. *Workstation/Laptop encryption.*** All workstations and laptops that process and/or store DHCS PHI or PI must be encrypted using a FIPS 140-2 certified algorithm which is 128bit or higher, such as Advanced Encryption Standard (AES). The encryption solution must be full disk unless approved by the DHCS Information Security Office.
- B. *Server Security.*** Servers containing unencrypted DHCS PHI or PI must have sufficient administrative, physical, and technical controls in place to protect that data, based upon a risk assessment/system security review.
- C. *Minimum Necessary.*** Only the minimum necessary amount of DHCS PHI or PI required to perform necessary business functions may be copied, downloaded, or exported.
- D. *Removable media devices.*** All electronic files that contain DHCS PHI or PI data must be encrypted when stored on any removable media or portable device (i.e. USB thumb drives, floppies, CD/DVD, smartphones, backup tapes etc.). Encryption must be a FIPS 140-2 certified algorithm which is 128bit or higher, such as AES.

Health Insurance Portability and Accountability Act (HIPAA) Business Associate Addendum

- E. *Antivirus software.*** All workstations, laptops and other systems that process and/or store DHCS PHI or PI must install and actively use comprehensive anti-virus software solution with automatic updates scheduled at least daily.
- F. *Patch Management.*** All workstations, laptops and other systems that process and/or store DHCS PHI or PI must have critical security patches applied, with system reboot if necessary. There must be a documented patch management process which determines installation timeframe based on risk assessment and vendor recommendations. At a maximum, all applicable patches must be installed within 30 days of vendor release.
- G. *User IDs and Password Controls.*** All users must be issued a unique user name for accessing DHCS PHI or PI. Username must be promptly disabled, deleted, or the password changed upon the transfer or termination of an employee with knowledge of the password, at maximum within 24 hours. Passwords are not to be shared. Passwords must be at least eight characters and must be a non-dictionary word. Passwords must not be stored in readable format on the computer. Passwords must be changed every 90 days, preferably every 60 days. Passwords must be changed if revealed or compromised. Passwords must be composed of characters from at least three of the following four groups from the standard keyboard:
- Upper case letters (A-Z)
 - Lower case letters (a-z)
 - Arabic numerals (0-9)
 - Non-alphanumeric characters (punctuation symbols)
- H. *Data Destruction.*** When no longer needed, all DHCS PHI or PI must be cleared, purged, or destroyed consistent with NIST Special Publication 800-88, Guidelines for Media Sanitization such that the PHI or PI cannot be retrieved.
- I. *System Timeout.*** The system providing access to DHCS PHI or PI must provide an automatic timeout, requiring re-authentication of the user session after no more than 20 minutes of inactivity.
- J. *Warning Banners.*** All systems providing access to DHCS PHI or PI must display a warning banner stating that data is confidential, systems are logged, and system use is for business purposes only by authorized users. User must be directed to log off the system if they do not agree with these requirements.
- K. *System Logging.*** The system must maintain an automated audit trail which can identify the user or system process which initiates a request for DHCS PHI or PI, or which alters DHCS PHI or PI. The audit trail must be date and time stamped, must log both successful and failed accesses, must be read only, and must be restricted to authorized users. If DHCS PHI or PI is stored in a database, database logging functionality must be enabled. Audit trail data must be archived for at least 3 years after occurrence.
- L. *Access Controls.*** The system providing access to DHCS PHI or PI must use role based access controls for all user authentications, enforcing the principle of least privilege.

Health Insurance Portability and Accountability Act (HIPAA) Business Associate Addendum

- M. *Transmission encryption.*** All data transmissions of DHCS PHI or PI outside the secure internal network must be encrypted using a FIPS 140-2 certified algorithm which is 128bit or higher, such as AES. Encryption can be end to end at the network level, or the data files containing PHI can be encrypted. This requirement pertains to any type of PHI or PI in motion such as website access, file transfer, and E-Mail.
- N. *Intrusion Detection.*** All systems involved in accessing, holding, transporting, and protecting DHCS PHI or PI that are accessible via the Internet must be protected by a comprehensive intrusion detection and prevention solution.

III. Audit Controls

- A. *System Security Review.*** All systems processing and/or storing DHCS PHI or PI must have at least an annual system risk assessment/security review which provides assurance that administrative, physical, and technical controls are functioning effectively and providing adequate levels of protection. Reviews should include vulnerability scanning tools.
- B. *Log Reviews.*** All systems processing and/or storing DHCS PHI or PI must have a routine procedure in place to review system logs for unauthorized access.
- C. *Change Control.*** All systems processing and/or storing DHCS PHI or PI must have a documented change control procedure that ensures separation of duties and protects the confidentiality, integrity and availability of data.

IV. Business Continuity / Disaster Recovery Controls

- A. *Emergency Mode Operation Plan.*** Contractor must establish a documented plan to enable continuation of critical business processes and protection of the security of electronic DHCS PHI or PI in the event of an emergency. Emergency means any circumstance or situation that causes normal computer operations to become unavailable for use in performing the work required under this Agreement for more than 24 hours.
- B. *Data Backup Plan.*** Contractor must have established documented procedures to backup DHCS PHI to maintain retrievable exact copies of DHCS PHI or PI. The plan must include a regular schedule for making backups, storing backups offsite, an inventory of backup media, and an estimate of the amount of time needed to restore DHCS PHI or PI should it be lost. At a minimum, the schedule must be a weekly full backup and monthly offsite storage of DHCS data.

V. Paper Document Controls

- A. *Supervision of Data.*** DHCS PHI or PI in paper form shall not be left unattended at any time, unless it is locked in a file cabinet, file room, desk or office. Unattended means that information is not being observed by an employee authorized to access the information. DHCS PHI or PI in paper form shall not be left unattended at any time in vehicles or planes and shall not be checked in baggage on commercial airplanes.
- B. *Escorting Visitors.*** Visitors to areas where DHCS PHI or PI is contained shall be escorted and DHCS PHI or PI shall be kept out of sight while visitors are in the area.

Health Insurance Portability and Accountability Act (HIPAA) Business Associate
Addendum

- C. Confidential Destruction.** DHCS PHI or PI must be disposed of through confidential means, such as cross cut shredding and pulverizing.
- D. Removal of Data.** DHCS PHI or PI must not be removed from the premises of the Contractor except with express written permission of DHCS.
- E. Faxing.** Faxes containing DHCS PHI or PI shall not be left unattended and fax machines shall be in secure areas. Faxes shall contain a confidentiality statement notifying persons receiving faxes in error to destroy them. Fax numbers shall be verified with the intended recipient before sending the fax.
- F. Mailing.** Mailings of DHCS PHI or PI shall be sealed and secured from damage or inappropriate viewing of PHI or PI to the extent possible. Mailings which include 500 or more individually identifiable records of DHCS PHI or PI in a single package shall be sent using a tracked mailing method which includes verification of delivery and receipt, unless the prior written permission of DHCS to use another method is obtained.

Exhibit H
Information Confidentiality and Security Requirements

1. **Definitions.** For purposes of this Exhibit, the following definitions shall apply:
 - A. **Public Information:** Information that is not exempt from disclosure under the provisions of the California Public Records Act (Government Code sections 6250-6265) or other applicable state or federal laws.
 - B. **Confidential Information:** Information that is exempt from disclosure under the provisions of the California Public Records Act (Government Code sections 6250-6265) or other applicable state or federal laws.
 - C. **Sensitive Information:** Information that requires special precautions to protect from unauthorized use, access, disclosure, modification, loss, or deletion. Sensitive Information may be either Public Information or Confidential Information. It is information that requires a higher than normal assurance of accuracy and completeness. Thus, the key factor for Sensitive Information is that of integrity. Typically, Sensitive Information includes records of agency financial transactions and regulatory actions.
 - D. **Personal Information:** Information that identifies or describes an individual, including, but not limited to, their name, social security number, physical description, home address, home telephone number, education, financial matters, and medical or employment history. **It is DHCS' policy to consider all information about individuals private unless such information is determined to be a public record.** This information must be protected from inappropriate access, use, or disclosure and must be made accessible to data subjects upon request. Personal Information includes the following:

Notice-triggering Personal Information: Specific items of personal information (name plus Social Security number, driver license/California identification card number, or financial account number) that may trigger a requirement to notify individuals if it is acquired by an unauthorized person. For purposes of this provision, identity shall include, but not be limited to name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph. See Civil Code sections 1798.29 and 1798.82.
2. **Nondisclosure.** The Contractor and its employees, agents, or subcontractors shall protect from unauthorized disclosure any Personal Information, Sensitive Information, or Confidential Information (hereinafter identified as PSCI).
3. The Contractor and its employees, agents, or subcontractors shall not use any PSCI for any purpose other than carrying out the Contractor's obligations under this Agreement.
4. The Contractor and its employees, agents, or subcontractors shall promptly transmit to the DHCS Program Contract Manager all requests for disclosure of any PSCI not emanating from the person who is the subject of PSCI.
5. The Contractor shall not disclose, except as otherwise specifically permitted by this Agreement or authorized by the person who is the subject of PSCI, any PSCI to anyone other than DHCS without prior written authorization from the DHCS Program Contract Manager, except if disclosure is required by State or Federal law.

6. The Contractor shall observe the following requirements:

A. Safeguards. The Contractor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PSCI, including electronic PSCI that it creates, receives, maintains, uses, or transmits on behalf of DHCS. Contractor shall develop and maintain a written information privacy and security program that includes administrative, technical and physical safeguards appropriate to the size and complexity of the Contractor's operations and the nature and scope of its activities, including at a minimum the following safeguards:

1) Personnel Controls

- a. Employee Training.** All workforce members who assist in the performance of functions or activities on behalf of DHCS, or access or disclose DHCS PSCI, must complete information privacy and security training, at least annually, at Business Associate's expense. Each workforce member who receives information privacy and security training must sign a certification, indicating the member's name and the date on which the training was completed. These certifications must be retained for a period of six (6) years following contract termination.
- b. Employee Discipline.** Appropriate sanctions must be applied against workforce members who fail to comply with privacy policies and procedures or any provisions of these requirements, including termination of employment where appropriate.
- c. Confidentiality Statement.** All persons that will be working with DHCS PHI or PI must sign a confidentiality statement that includes, at a minimum, General Use, Security and Privacy Safeguards, Unacceptable Use, and Enforcement Policies. The statement must be signed by the workforce member prior to access to DHCS PHI or PI. The statement must be renewed annually. The Contractor shall retain each person's written confidentiality statement for DHCS inspection for a period of six (6) years following contract termination.
- d. Background Check.** Before a member of the workforce may access DHCS PHI or PI, a thorough background check of that worker must be conducted, with evaluation of the results to assure that there is no indication that the worker may present a risk to the security or integrity of confidential data or a risk for theft or misuse of confidential data. The Contractor shall retain each workforce member's background check documentation for a period of three (3) years following contract termination.

2) Technical Security Controls

- a. Workstation/Laptop encryption.** All workstations and laptops that process and/or store DHCS PHI or PI must be encrypted using a FIPS 140-2 certified algorithm which is 128bit or higher, such as Advanced Encryption Standard (AES). The encryption solution must be full disk unless approved by the DHCS Information Security Office.
- b. Server Security.** Servers containing unencrypted DHCS PHI or PI must have sufficient administrative, physical, and technical controls in place to protect that data, based upon a risk assessment/system security review.

- c. **Minimum Necessary.** Only the minimum necessary amount of DHCS PHI or PI required to perform necessary business functions may be copied, downloaded, or exported.
- d. **Removable media devices.** All electronic files that contain DHCS PHI or PI data must be encrypted when stored on any removable media or portable device (i.e. USB thumb drives, floppies, CD/DVD, Blackberry, backup tapes etc.). Encryption must be a FIPS 140-2 certified algorithm which is 128bit or higher, such as AES.
- e. **Antivirus software.** All workstations, laptops and other systems that process and/or store DHCS PHI or PI must install and actively use comprehensive anti-virus software solution with automatic updates scheduled at least daily.
- f. **Patch Management.** All workstations, laptops and other systems that process and/or store DHCS PHI or PI must have critical security patches applied, with system reboot if necessary. There must be a documented patch management process which determines installation timeframe based on risk assessment and vendor recommendations. At a maximum, all applicable patches must be installed within 30 days of vendor release.
- g. **User IDs and Password Controls.** All users must be issued a unique user name for accessing DHCS PHI or PI. Username must be promptly disabled, deleted, or the password changed upon the transfer or termination of an employee with knowledge of the password, at maximum within 24 hours. Passwords are not to be shared. Passwords must be at least eight characters and must be a non-dictionary word. Passwords must not be stored in readable format on the computer. Passwords must be changed every 90 days, preferably every 60 days. Passwords must be changed if revealed or compromised. Passwords must be composed of characters from at least three of the following four groups from the standard keyboard:
- Upper case letters (A-Z)
 - Lower case letters (a-z)
 - Arabic numerals (0-9)
 - Non-alphanumeric characters (punctuation symbols)
- h. **Data Destruction.** When no longer needed, all DHCS PHI or PI must be wiped using the Gutmann or US Department of Defense (DoD) 5220.22-M (7 Pass) standard, or by degaussing. Media may also be physically destroyed in accordance with NIST Special Publication 800-88. Other methods require prior written permission of the DHCS Information Security Office.
- i. **System Timeout.** The system providing access to DHCS PHI or PI must provide an automatic timeout, requiring re-authentication of the user session after no more than 20 minutes of inactivity.
- j. **Warning Banners.** All systems providing access to DHCS PHI or PI must display a warning banner stating that data is confidential, systems are logged, and system use is for business purposes only by authorized users. User must be directed to log off the system if they do not agree with these requirements.
- k. **System Logging.** The system must maintain an automated audit trail which can identify the user or system process which initiates a request for DHCS PHI or PI, or which alters DHCS PHI or PI. The audit trail must be date and time stamped, must log both successful

and failed accesses, must be read only, and must be restricted to authorized users. If DHCS PHI or PI is stored in a database, database logging functionality must be enabled. Audit trail data must be archived for at least 3 years after occurrence.

- l. Access Controls.** The system providing access to DHCS PHI or PI must use role based access controls for all user authentications, enforcing the principle of least privilege.
- m. Transmission encryption.** All data transmissions of DHCS PHI or PI outside the secure internal network must be encrypted using a FIPS 140-2 certified algorithm which is 128bit or higher, such as AES. Encryption can be end to end at the network level, or the data files containing PHI can be encrypted. This requirement pertains to any type of PHI or PI in motion such as website access, file transfer, and E-Mail.
- n. Intrusion Detection.** All systems involved in accessing, holding, transporting, and protecting DHCS PHI or PI that are accessible via the Internet must be protected by a comprehensive intrusion detection and prevention solution.

3) Audit Controls

- a. System Security Review.** All systems processing and/or storing DHCS PHI or PI must have at least an annual system risk assessment/security review which provides assurance that administrative, physical, and technical controls are functioning effectively and providing adequate levels of protection. Reviews should include vulnerability scanning tools.
- b. Log Reviews.** All systems processing and/or storing DHCS PHI or PI must have a routine procedure in place to review system logs for unauthorized access.
- c. Change Control.** All systems processing and/or storing DHCS PHI or PI must have a documented change control procedure that ensures separation of duties and protects the confidentiality, integrity and availability of data.

4) Business Continuity / Disaster Recovery Controls

- a. Emergency Mode Operation Plan.** Contractor must establish a documented plan to enable continuation of critical business processes and protection of the security of electronic DHCS PHI or PI in the event of an emergency. Emergency means any circumstance or situation that causes normal computer operations to become unavailable for use in performing the work required under this Agreement for more than 24 hours.
- b. Data Backup Plan.** Contractor must have established documented procedures to backup DHCS PHI to maintain retrievable exact copies of DHCS PHI or PI. The plan must include a regular schedule for making backups, storing backups offsite, an inventory of backup media, and an estimate of the amount of time needed to restore DHCS PHI or PI should it be lost. At a minimum, the schedule must be a weekly full backup and monthly offsite storage of DHCS data.

5) Paper Document Controls

- a. Supervision of Data.** DHCS PHI or PI in paper form shall not be left unattended at any time, unless it is locked in a file cabinet, file room, desk or office. Unattended means that

information is not being observed by an employee authorized to access the information. DHCS PHI or PI in paper form shall not be left unattended at any time in vehicles or planes and shall not be checked in baggage on commercial airplanes.

- b. **Escorting Visitors.** Visitors to areas where DHCS PHI or PI is contained shall be escorted and DHCS PHI or PI shall be kept out of sight while visitors are in the area.
 - c. **Confidential Destruction.** DHCS PHI or PI must be disposed of through confidential means, such as cross cut shredding and pulverizing.
 - d. **Removal of Data.** DHCS PHI or PI must not be removed from the premises of the Contractor except with express written permission of DHCS.
 - e. **Faxing.** Faxes containing DHCS PHI or PI shall not be left unattended and fax machines shall be in secure areas. Faxes shall contain a confidentiality statement notifying persons receiving faxes in error to destroy them. Fax numbers shall be verified with the intended recipient before sending the fax.
 - f. **Mailing.** Mailings of DHCS PHI or PI shall be sealed and secured from damage or inappropriate viewing of PHI or PI to the extent possible. Mailings which include 500 or more individually identifiable records of DHCS PHI or PI in a single package shall be sent using a tracked mailing method which includes verification of delivery and receipt, unless the prior written permission of DHCS to use another method is obtained.
- B. Security Officer.** The Contractor shall designate a Security Officer to oversee its data security program who will be responsible for carrying out its privacy and security programs and for communicating on security matters with DHCS.
- C. Discovery and Notification of Breach.** The Contractor shall notify DHCS **immediately by telephone call plus email or fax** upon the discovery of breach of security of PSCI in computerized form if the PSCI was, or is reasonably believed to have been, acquired by an unauthorized person, or upon the discovery of a suspected security incident that involves data provided to DHCS by the Social Security Administration **or within twenty-four (24) hours by email or fax** of the discovery of any suspected security incident, intrusion or unauthorized use or disclosure of PSCI in violation of this Agreement, or potential loss of confidential data affecting this Agreement. Notification shall be provided to the DHCS Program Contract Manager, the DHCS Privacy Officer and the DHCS Information Security Officer. Notice shall be made using the "DHCS Privacy Incident Report" form, including all information known at the time. The Contractor shall use the most current version of this form, which is posted on the DHCS Privacy Office website (www.dhcs.ca.gov, then select "Privacy" in the left column and then "Business Use" near the middle of the page) or use this link: <http://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/DHCSBusinessAssociatesOnly.aspx> If the incident occurs after business hours or on a weekend or holiday and involves electronic PSCI, notification shall be provided by calling the DHCS Information Technology Services Division (ITSD) Help Desk. Contractor shall take:
- 1) Prompt corrective action to mitigate any risks or damages involved with the breach and to protect the operating environment and
 - 2) Any action pertaining to such unauthorized disclosure required by applicable Federal and State laws and regulations.

- D. Investigation of Breach.** The Contractor shall immediately investigate such security incident, breach, or unauthorized use or disclosure of PSCI and within seventy-two (72) hours of the discovery, The Contractor shall submit an updated “DHCS Privacy Incident Report” containing the information marked with an asterisk and all other applicable information listed on the form, to the extent known at that time, to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer:
- E. Written Report.** The Contractor shall provide a written report of the investigation to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer within ten (10) working days of the discovery of the breach or unauthorized use or disclosure. The report shall include, but not be limited to, the information specified above, as well as a full, detailed corrective action plan, including information on measures that were taken to halt and/or contain the improper use or disclosure.
- F. Notification of Individuals.** The Contractor shall notify individuals of the breach or unauthorized use or disclosure when notification is required under state or federal law and shall pay any costs of such notifications, as well as any costs associated with the breach. The DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer shall approve the time, manner and content of any such notifications.
- 7. Affect on lower tier transactions.** The terms of this Exhibit shall apply to all contracts, subcontracts, and subawards, regardless of whether they are for the acquisition of services, goods, or commodities. The Contractor shall incorporate the contents of this Exhibit into each subcontract or subaward to its agents, subcontractors, or independent consultants.
- 8. Contact Information.** To direct communications to the above referenced DHCS staff, the Contractor shall initiate contact as indicated herein. DHCS reserves the right to make changes to the contact information below by giving written notice to the Contractor. Said changes shall not require an amendment to this Exhibit or the Agreement to which it is incorporated.

DHCS Program Contract Manager	DHCS Privacy Officer	DHCS Information Security Officer
See the Scope of Work exhibit for Program Contract Manager information	Privacy Officer c/o Office of Legal Services Department of Health Care Services P.O. Box 997413, MS 0011 Sacramento, CA 95899-7413 Email: privacyofficer@dhcs.ca.gov Telephone: (916) 445-4646	Information Security Officer DHCS Information Security Office P.O. Box 997413, MS 6400 Sacramento, CA 95899-7413 Email: iso@dhcs.ca.gov Telephone: ITSD Help Desk (916) 440-7000 or (800) 579-0874

- 9. Audits and Inspections.** From time to time, DHCS may inspect the facilities, systems, books and records of the Contractor to monitor compliance with the safeguards required in the Information Confidentiality and Security Requirements (ICSR) exhibit. Contractor shall promptly remedy any violation of any provision of this ICSR exhibit. The fact that DHCS inspects, or fails to inspect, or has the right to inspect, Contractor’s facilities, systems and procedures does not relieve Contractor of its responsibility to comply with this ICSR exhibit.

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

**Attachment II: Managed Care Enrollment Proposed Aid Code Group
Coverage**

A breakdown of MCMC enrollment by aid code group and MCMC model is included for reference in the following attachment.

Attachment II: Managed Care Enrollment Proposed Aid Code Group Coverage

Managed Care Enrollment										
Aid Code Group Coverage										
		Current			2022			2023		
Aid Code Group	Non- Dual/ Dual ¹	Mandatory	Voluntary	Excluded from Enrollment	Mandatory	Voluntary	Excluded from Enrollment	Mandatory	Voluntary	Excluded from Enrollment
Adult Expansion	Non- Dual	All Models	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A
Non-Disabled Adults (19 & Over)	Non- Dual	All Models	N/A	N/A	All Models	N/A	SOC	All Models	N/A	SOC
Aged	Non- Dual	All Models	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A
Breast and Cervical Cancer Treatment Program (BCCTP)	Non- Dual	All Models	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A

Managed Care Enrollment										
Aid Code Group Coverage										
		Current			2022			2023		
Aid Code Group	Non- Dual/ Dual ¹	Mandatory	Voluntary	Excluded from Enrollment	Mandatory	Voluntary	Excluded from Enrollment	Mandatory	Voluntary	Excluded from Enrollment
Disabled	Non- Dual	All Models	N/A	N/A	All Models	N/A	SOC	All Models	N/A	SOC
Long Term Care (includes LTC SOC)	Non- Dual	COHS, CCI	N/A	All Other Models	COHS, CCI	N/A	All Other Models	All Models	N/A	N/A
Foster Children	Non- Dual	COHS	Non- COHS	N/A	COHS	Non- COHS	N/A	COHS	Non- COHS	N/A
Omnibus Budget Reconciliation Act (OBRA) Restricted Scope Only	Both	Napa, Solano, and Yolo counties	N/A	All Other Models	N/A	N/A	All Models	N/A	N/A	All Models

Managed Care Enrollment										
Aid Code Group Coverage										
		Current			2022			2023		
Aid Code Group	Non- Dual/ Dual ¹	Mandatory	Voluntary	Excluded from Enrollment	Mandatory	Voluntary	Excluded from Enrollment	Mandatory	Voluntary	Excluded from Enrollment
Share of Cost	Non- Dual	COHS & CCI	N/A	All Other Models	N/A	N/A	All Models	N/A	N/A	All Models
Non-Disabled Adults (19 & Over)	Dual	COHS, CCI	All Other Models	N/A	COHS, CCI	All Other Models	SOC	All Models	N/A	SOC
Non-Disabled Children (Under 19)	Dual	COHS, CCI	All Other Models	N/A	COHS, CCI	All Other Models	SOC	All Models	N/A	SOC
Aged	Dual	COHS, CCI	All Other Models	N/A	COHS, CCI	All Other Models	N/A	All Models	N/A	N/A

Managed Care Enrollment										
Aid Code Group Coverage										
		Current			2022			2023		
Aid Code Group	Non-Dual/ Dual ¹	Mandatory	Voluntary	Excluded from Enrollment	Mandatory	Voluntary	Excluded from Enrollment	Mandatory	Voluntary	Excluded from Enrollment
Breast and Cervical Cancer Treatment Program (BCCTP)	Dual	COHS, CCI	All Other Models	N/A	COHS, CCI	All Other Models	N/A	All Models	N/A	N/A
Disabled	Dual	COHS, CCI	All Other Models	N/A	COHS, CCI	All Other Models	SOC	All Models	N/A	SOC
Long Term Care (includes LTC SOC)	Dual	COHS, CCI	All Other Models	N/A	COHS, CCI	All Other Models	N/A	All Models	N/A	N/A
Share of Cost	Dual	COHS, CCI	N/A	Non-COHS & Non-CCI	N/A	N/A	All Models	N/A	N/A	All Models

Managed Care Enrollment										
Aid Code Group Coverage										
		Current			2022			2023		
Aid Code Group	Non- Dual/ Dual ¹	Mandatory	Voluntary	Excluded from Enrollment	Mandatory	Voluntary	Excluded from Enrollment	Mandatory	Voluntary	Excluded from Enrollment
Presumptive Eligibility (Hospital and CHDP PE)	Both	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A	All Models
Trafficking and Crime Victims Assistance Program (TCVAP)	Both	N/A	N/A	All Models	All Models	N/A	TCVAP SOC	All Models	N/A	TCVAP SOC
Accelerated Enrollment (AE)	Both	N/A	N/A	All Models	All Models	N/A	N/A	All Models	N/A	N/A
Child Health and Disability Prevention (CHDP) Infant Deeming²	Both	8U	N/A	8V	All Models	N/A	CHDP SOC	All Models	N/A	CHDP SOC

Managed Care Enrollment										
Aid Code Group Coverage										
		Current			2022			2023		
Aid Code Group	Non- Dual/ Dual ¹	Mandatory	Voluntary	Excluded from Enrollment	Mandatory	Voluntary	Excluded from Enrollment	Mandatory	Voluntary	Excluded from Enrollment
State Medical Parole/County Compassionate Release/ Incarcerated Individuals	N/A	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A	All Models
Limited/Restricted Scope Eligible	Both	Except for OBRA in Napa, Solano and Yolo	N/A	All Models	N/A	N/A	All Models	N/A	N/A	All Models

Pregnancy Related Aid Codes					
	Citizen/Lawfully Present			Non-Citizen	
	Current	Proposed (2022)		Current	Proposed (2022)
Title XXI (SCHIP) 213-322%	Full Scope/MC	Full Scope/MC	Title XXI (SCHIP) 213-322%	Full Scope/MC	Full Scope/MC
Title XIX (PRS/ES) 138-213%	Limited Scope/FFS	Full Scope/MC	Title XXI (PRS – SCHIP) Title XIX (ES) 138-213%	Limited Scope/FFS	Limited Scope/FFS
Title XIX (PRS/ES) 0-138%	Full Scope/MC	Full Scope/MC	Title XXI (PRS – SCHIP) Title XIX (ES) 0-138%	Limited Scope/FFS	Limited Scope/FFS

Population Exclusions									
Populations	Current			2022			2023		
	Mandatory	Voluntary	Excluded from Enrollment	Mandatory	Voluntary	Excluded from Enrollment	Mandatory	Voluntary	Excluded from Enrollment
American Indian ³	COHS	Non-COHS	N/A	All Models ⁴	N/A	N/A	All Models ⁴	N/A	N/A
Beneficiaries with Other Healthcare Coverage (OHC)	COHS	N/A	Non-COHS	All Models ⁴	N/A	N/A	All Models ⁴	N/A	N/A
Beneficiaries in Rural Zip Codes ⁵	COHS	Non- COHS	Non-COHS	All Models ⁴	N/A	N/A	All Models ⁴	N/A	N/A
Beneficiaries in Home and Community Based Services Waivers	COHS & CCI MLTSS = All Non-COHS & Non-CCI = Non- Duals	Non- COHS & Non-CCI = Duals	Cal MediConnect	COHS & CCI MLTSS = All Non-COHS & Non- CCI = Non-Duals	Non-COHS & Non-CCI = Duals	Cal MediConnect	All Models ⁴	N/A	N/A

¹ Non-Dual/Dual Definitions: (1) Non-Dual – A Medi-Cal only beneficiary or a Medi-Cal only beneficiary with Medicare Part A or Part B only; (2) Dual – Medi-Cal only beneficiary with Medicare Part A and Part B or Medicare Part A, B, and D.

² No changes to the CHDP Infant Deeming aid code group since 8U is currently in mandatory managed care. 8V will remain in Medi-Cal fee-for-service since this aid code has a Share-of-Cost (SOC).

³ American Indian Beneficiaries will be enrolled into a managed care plan, but they will have the option to opt out of enrollment if they choose to remain in FFS

⁴ Would align with Mandatory/Voluntary/Excluded MC Enrollment by aid code, no special exclusions from enrollment solely based on zip code, OHC, American Indian or 1915c Waiver Enrollment

⁵ The following zip codes are currently excluded from enrollment or are voluntary for enrollment: 93558, 90704, 92225, 92226, 92239, 92242, 92267, 92280, 92323, 92332, 92363, 92364, 92366, 93562, 9359293555, 93556, 93560, 92252, 92256, 92268, 92277, 92278, 92284, 92285, 92286, 92304, 92305, 92309, 92310, 92311, 92312, 92314, 92315, 92317, 92321, 92322, 92325, 92327, 92333, 92338, 92339, 92341, 92342, 92347, 92352, 92356, 92358, 92365, 92368, 92372, 92378, 92382, 92385, 92386, 92391, 92397, 92398