Exhibit A
Scope of Work

1. Service Overview

Contractor agrees to provide to the Department of Health Care Services (DHCS or the Department) the services described herein as part of the Contractor's operation of a Program of All-Inclusive Care for the Elderly (PACE) program:

Provide covered services under the PACE benefit of the Medi-Cal program to eligible Medi-Cal recipients enrolled in the Contractor's PACE plan as defined in the contents of the Contract and as set forth in:

A. federal law, including but not limited to: Title 42 United States Code (U.S.C.) section 1395eee and 1396u-4; Title 42 Code of Federal Regulations (42 CFR), Chapter IV, Subchapter E; and all federal guidance regarding PACE plans;

B. state law, including but not limited to California Welfare & Institutions Code section 14132.94; Chapter 8.75 of Part 3, Division 9, of the Welfare & Institutions Code; and all PACE Letters issued by DHCS.

See Exhibit A, Attachment 1 through 17 for a detailed description of the services to be performed.

2. Service Location

The services shall be furnished in at least the PACE center, the home and inpatient facilities.

3. Service Hours

The Contractor shall furnish access to necessary covered services that meet the needs of each member in the all care settings 24 hours a day, every day of the year.

4. Project Representatives

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

Department of Health Care Services	**PACE Plan Name**
Integrated Systems of Care Division	PACE Representative
Contract Manager	Executive Director/CEO
Telephone:	Telephone:
Email:	Email:

Exhibit A
Scope of Work

B. Direct all inquiries to:

Department of Health Care Services	**PACE Plan name**
Integrated Systems of Care Division	Attention: Executive Director/CEO
Attention: Elva Alatorre	PACE Address
1515 K Street, Suite 340	City, CA Zip Code
Sacramento CA 95814	Telephone:
Email:	Email

C. Either party may make changes to the Project Representative information above by giving written notice to the other party. Said changes shall not require an amendment to this agreement.

5. See the following pages for a detailed description of the services to be performed.

6. Americans with Disabilities Act

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

Exhibit A, Attachment 1
Organization and Administration of the Plan

1. Legal Capacity

Contractor shall maintain the legal capacity to contract with DHCS and maintain all appropriate licenses, as determined by and at the sole discretion of DHCS, to operate a Program of All-Inclusive Care for the Elderly (PACE).

If Contractor does not operate a primary care clinic licensed to operate by the California Department of Public Health pursuant to California Code, section 1204, et seq., then Contractor must operate its primary care clinic in accordance with all requirements applicable to the operation of licensed Primary Care clinics, subject to oversight and approval of the DHCS. If Contractor fails to comply with the requirements for operation of a licensed primary care clinic, the DHCS may require Contractor to submit a Corrective Action Plan (CAP). If Contractor does not carry out the CAP to comply with the requirements for operation of a licensed primary care clinic, the DHCS may terminate this contract.

2. Key Personnel: Disclosure Form

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

1) any person or corporation having 5% or more ownership or controlling a substantial financial interest in Contractor;

2) any director, officer, partner, trustee, or employee of Contractor; or

3) any immediate family member of any person designated in (1) or (2) above.

Contractor shall ensure that individuals on its governing body, and their family members comply with conflict of interest requirements specified in 42 CFR, Section 460.68(b) and Welfare & Institutions Code Sections 14030, 14031, and 14032.

B. Organizational Chart

1) Contractor shall provide DHCS with a current organizational chart showing officials in the PACE organization and relationships to any other organizational entities. The organizational chart shall show where the Contractor PACE Organization relates to the other

entities and the reporting structure from the governing body to the Contractor PACE organization.

2) The chart for a corporate entity must indicate the Contractor's relationship to the corporate board and to any parent, affiliate, or subsidiary corporate entities.

3) If Contractor is planning a change in organizational structure, it must notify DHCS, in writing, at least 14 days before the change takes effect.

3. Conflict of Interest: Current and Former State Employees

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 whose employment with the State in any way involves or is related to the operation, oversight, approval, contracting or establishment of PACE plans, unless the employment, activity or enterprise is required as a condition of the officer's or employee's regular state employment. For purposes of this subsection only, employee in the State civil service means any person legally holding a permanent or intermittent position in the State civil service.

4. Contract Performance

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

A. Contractor has an accountable governing body with full legal authority and responsibility, as required in 42 CFR, Section 460.62(a).

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

C. If Contractor is a subsidiary, the attestation of the parent organization that this Contract shall be a high priority to the parent, and that the parent is committed to supplying any and all necessary resources to assure full performance of the Contract.

D. Contractor has a full-time Program Director who is responsible for the oversight and administration of the PACE plan, as required by 42 CFR 460.60.

Exhibit A, Attachment 1
Organization and Administration of the Plan

E. Contractor has sufficient support staff to conduct Contractor's daily business in an orderly manner, as determined through management, medical, dental, and fiscal reviews conducted or requested by DHCS.

F. Contractor's representation on the governing body includes a member representative when issues related to member care, are under consideration, as required by 42 CFR, Section 460.62(c).

G. Contractor has established a Participant advisory committee, as required by 42 CFR 460.62(b).

H. If Contractor is planning to change its organizational structure, written notification describing that change must be provided to DHCS, at least 14 days before the change would take effect, in order to obtain DHCS approval to continue this contract under the new organizational structure in compliance with Medi-Cal and Medicaid laws and regulations.

I. Contractor shall:

1) collect data;

2) maintain, and afford DHCS access to, the records relating to the program, including pertinent financial, medical, and personnel records;

3) make available to DHCS reports that DHCS considers necessary to monitor the operation, cost, and effectiveness of the PACE program;

4) during the first 3 years of operation of a PACE program, provide such additional data as DHCS specifies in order to perform the oversight required during the initial 3 year trial period;

5) maintain records and report data in compliance with 42 U.S.C. Section 1395eee(e)(3) and 42 CFR 460.32(a)(11), 460.202, 460.204, 460.208, and 460.210.

J. Contractor shall meet all applicable requirements under Federal, State, and local laws and regulations, including Section 1557 of the Affordable Care Act, the Civil Rights Act, the Age Discrimination Act, Section 504 of the Rehabilitation Act, the Americans With Disabilities Act, and Section 11135 of the Government Code.

Exhibit A, Attachment 1
Organization and Administration of the Plan

5. Medical Decisions

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

6. Program Director

Contractor shall maintain a full-time Program Director whose duties include, but may not be limited to, the following responsibilities:

A. Ensuring oversight and administration within the organization;

B. Ensuring that decisions concerning medical, social, and supportive services decisions are not unduly influenced by fiscal or administrative management;

C. Ensuring that appropriate personnel perform their functions within the organization; and

D. Informing employees and contracted providers of applicable organization policies and procedures.

7. Medical Director

Contractor shall maintain a full time physician as Medical Director, in compliance with 42 CFR section 460.60, whose responsibilities shall include, but not be limited to, the following:

A. Ensuring that medical decisions are:

1) rendered by qualified medical personnel; and

2) are not unduly influenced by fiscal or administrative management considerations;

B. ensuring that provided medical care meets or exceeds the standards for acceptable medical care;

C. ensuring that medical protocols and rules of conduct for plan medical personnel are followed;

D. developing and implementing medical policy;

E. resolving grievances related to quality of medical care;

F. actively participating in Contractor's grievance procedures; and

G. actively participating in the implementation of Quality Improvement (QI) activities.

8. Medical Director Changes

Contractor shall report to DHCS any changes in the status of the Medical Director within ten calendar days.

9. Administrative Duties/Responsibilities

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

A. ensuring personnel meet all applicable state licensure, certification, or registration requirements;

B. providing on-going training, as required by 42 CFR, Section 460.66(a);

C. ensuring patient safety and to achieve patient-specific performance measures requiring actions necessary of each staff member (employees and contractors) to address different medical and non-medical emergencies;

D. Ensuring Contractor does not employ or contract with organizations or individuals:

1) who have been excluded from participation in the Medicare or Medicaid programs;

2) who have been convicted of criminal offenses related to their involvement in Medicaid, Medicare, other health insurance or health care programs, or social service programs under title XX of the Social Security Act;

3) If the PACE organization determines that an individual's contact with participants would pose a potential risk because the individual

has been convicted of one or more criminal offenses related to physical, sexual, drug, or alcohol abuse, or use;

4) who have been found guilty of abusing, neglecting, or mistreating individuals by a court of law or who have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents, or misappropriation of their property; or

5) who have been convicted of specific crimes for any offense described in section 1128(a) of the Social Security Act.

Contractor shall have a formal process in place to gather information related to this paragraph and shall respond in writing to a request for information from DHCS within a reasonable amount of time.

Contractor shall comply with the requirements of 42 CFR 460.86 regarding payment to individuals and entities excluded by the Office of the Inspector General or included on the preclusion list.

E. Designating persons qualified by training or experience, to be responsible for the Medical Record service.

F. establishing and maintaining member enrollment and Disenrollment reporting systems.

G. establishing and maintaining member grievance and appeals procedures, as specified in Exhibit A, Attachment 14.

H. establishing and maintaining data reporting capabilities sufficient to provide necessary and timely reports to DHCS, as required in Exhibit A, Attachment 3, and elsewhere in this contract.

I. maintaining financial records and books of account maintained on the accrual basis, in accordance with Generally Accepted Accounting Principles (GAAP), which fully discloses the disposition of all Medi-Cal program funds received, as specified in Exhibit A, Attachment 2.

J. establishing and maintaining claims processing capabilities as described in Exhibit A, Attachment 8.

K. Maintaining and affording DHCS access to the records relating to the program, including pertinent financial, medical, and personnel records.

L. Making available to DHCS reports that DHCS finds necessary to monitor the operation, cost, and effectiveness of the PACE program.

M. Cooperating with DHCS in the development and implementation of health status and quality of life outcome measures with respect to PACE program eligible individuals.

N. Identifying members of Contractor's governing body or any immediate family member having a direct or indirect interest in any contract that supplies any administrative or care-related service or materials to the PACE organization.

1) Contractor shall develop policies and procedures for handling any direct or indirect conflict of interest by a member of the governing body or by the member's immediate family.

2) In the event of a direct or indirect conflict of interest by a member of Contractor's governing body or his or her immediate family member, the board member must:

a. Fully disclose the exact nature of the conflict to the board of directors and have the disclosure documented; and

b. Recuse himself or herself from discussing, negotiating, or voting on any issue or contract that could result in an inappropriate conflict.

3) Contractor shall have a formal process in place to gather information related to this paragraph and must be able to respond in writing to a request for information from CMS and/or DHCS within a reasonable amount of time.

10. Member Representation

Contractor shall ensure that Medi-Cal Members, including Seniors and Persons with Disabilities (SPD) and persons with chronic conditions (such as asthma, diabetes, and congestive heart failure), are represented and participate in establishing public policy within the Contractor's Participant Advisory Committee.

11. Sensitivity Training

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

Exhibit A, Attachment 1
Organization and Administration of the Plan

12. Contract Oversight During Trial Period

Contractor shall be subject to annual, close oversight during the trial period, meaning the first 3 contract years as a PACE provider, as set forth in 42 U.S.C. Section 1496eee(e)(4) and 42 CFR 460.190. During the trial period, CMS and DHCS conduct a comprehensive annual review of the operation of Contractor's PACE program in order to assure compliance with the legal and contractual requirements. Such a review shall include:

A. an on-site visit to the program site;

B. comprehensive assessment of Contractor's fiscal soundness;

C. comprehensive assessment of Contractor's capacity to provide all PACE services to all enrolled members;

D. detailed analysis of Contractor's substantial compliance with all significant requirements of federal and state law and regulations; and

E. any other elements the Secretary or DHCS considers necessary or appropriate.

After the trial period, CMS in cooperation with DHCS will continue to conduct such review of the operation of Contractor and its PACE program as may be appropriate, taking into account Contractor's performance level and compliance with all significant requirements of law and regulations pursuant to 42 CFR 460.192

DHCS reserves the right to conduct audits of mature PACE Organizations outside of the joint CMS audit(s) as described above. This requirement is to ensure that all PACE Organizations comply with current state requirements along with contractual deliverables. The audits shall include but not limited to: an on-site visit at least every 3 years or as appropriate to address program deliverables, monitoring and oversight activities ensuring program compliance. The results of these reviews will be reported promptly to Contractor, along with any recommendations for changes to the Contractor's program, audit findings may be posted online to provide transparency.

As described in 42 CFR 460.194, Contractor must take action to correct deficiencies identified during reviews. CMS and/or DHCS monitors the effectiveness of the corrective actions. Failure to correct deficiencies may result in sanctions or termination. Disclosure of the review results is governed by 42 CFR 460.196.

Exhibit A, Attachment 1
Organization and Administration of the Plan

13. Oversight and Enforcement Authority

A. In general

If it is determined by DHCS or the Centers for Medicare and Medicaid Services (CMS) that Contractor is failing substantially to comply with the requirements of federal or state laws or regulations, CMS and DHCS may take any or all of the following actions:

1) Condition the continuation of the PACE program agreement upon timely execution of a corrective action plan.

2) Withhold some or all further payments under the PACE program agreement under 42 USC Section 1395eee(e)(6) or Section 1396u-4 with respect to PACE program services furnished by Contractor until the deficiencies have been corrected.

3) Terminate such agreement.

B. Application of intermediate sanctions

CMS may provide for the application against Contractor of remedies described in section 42 USC Sections 1395w-27(g)(2) or 1396b(m)(5)(B in the case of violations by the Contractor of the type described in sections 1395w-27(g)(1) or 1396b(m)(5)(A) of this title, respectively (in relation to agreements, enrollees, and requirements under this section or section 1396u-4, respectively).

C. DHCS Actions

DHCS may take enforcement action with respect to Contractor as described in Welfare & Institutions Code Section 14304.

Exhibit A, Attachment 2
Financial Information

1. Financial Viability/Standards Compliance

Contractor shall comply with the requirements of 42 CFR 460.80, and meet and maintain financial viability/standards compliance to DHCS' satisfaction for each of the following elements. To the extent that there is any conflict between State and federal law, or between this contract and federal law, the stricter of the requirements shall apply.

A. Tangible Net Equity (TNE)

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

B. Administrative Costs

Contractor's administrative costs shall not exceed the standards established under Title 28, CCR, Section 1300.78.

C. Standards of Organization and Financial Soundness

Contractor shall provide, and update as changes occur, a description of its organizational structure and information on administrative contacts including the following;

1) name and phone number of the program director;

2) name of all governing body members; and

3) name and phone number of a contact person for the governing body.

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

2. Financial Audit Reports

Contractor shall ensure that an annual audit is performed. A financial statement, audited by a Certified Public Accountant (CPA) shall be submitted to DHCS no later than 180 calendar days after the close of the 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 are 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. Contractor shall have separate certified financial statements prepared if an independent accountant decides that preparation of combined statements is inappropriate.

A. The independent accountant shall state in writing reasons for not preparing combined financial statements.

B. Contractor shall provide supplemental schedules that clearly reflect all inter-entity transactions and eliminations necessary to enable DHCS to analyze the overall financial status of the entire health care delivery system.

1) In addition to annual certified financial statements Contractor shall complete the State Department of Managed Health Care (DMHC) required financial reporting forms. The CPA audited financial statements and the DMHC required financial reporting forms shall be submitted to DHCS no later than 180 calendar days after the close of Contractor's Fiscal Year (FY).

2) If Contractor is a public entity or a political subdivision of the state and a county grand jury conducts Contractor’s financial audits, Contractor shall submit its financial statement within 180 calendar days after the close of the FY in accordance with Health and Safety Code, section 1384.

3) Contractor shall submit to DHCS within 45 calendar days after the close of Contractor's fiscal quarter, quarterly financial reports required by Title 22 CCR Section 53862(b)(1). The required quarterly financial reports shall be prepared on DMHC required financial reporting forms and shall include, at a minimum, the following reports/schedules:

a. Jurat;

b. Report 1A and 1B: Balance Sheet;

c. Report 2: Statement of Revenue, Expenses, and Net Worth;

d. Statement of Cash Flow, prepared in accordance with Financial Accounting Standards Board Statement Number

95 (This statement is prepared in lieu of Report #3: Statement of Changes in Financial Position for GAAP compliance);

e. Report 4: Enrollment and Utilization Table;

f. Schedule F: Unpaid Claims Analysis;

g. Appropriate footnote disclosures in accordance with GAAP; and

h. Schedule H: Aging Of All Claims

C. Contractor shall authorize the independent accountant to allow DHCS designated representatives or agents, upon written request, to inspect any and all working papers related to the preparation of the audit report.

D. Contractor shall submit to DHCS all financial reports relevant to Affiliates as specified in Title 22 CCR Section 53330(a)(1) and 53862(c)(4).

E. Contractor shall submit to DHCS copies of any financial reports submitted to other public or private organizations as specified in Title 22, CCR, Section 53324(d).

3. Monthly Financial Statements

If Contractor and/or subcontractor is required to file monthly financial statements with the DMHC, Contractor and/or subcontractor shall file an exact copy of the monthly financial statements with DHCS. Contractor and/or subcontractor shall submit monthly financial statements to DHCS upon request, if deemed necessary, to monitor the Contractor and/or subcontractor's financial viability.

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

A. Jurat;

B. Report 1A and 1B: Balance Sheet;

C. Report 2: Statement of Revenue, Expenses, and Net Worth;

Exhibit A, Attachment 2
Financial Information

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 GAAP compliance;

E. Report 4: Enrollment and Utilization Table;

F. Schedule F: Unpaid Claims Analysis;

G. appropriate footnote disclosures in accordance with GAAP; and

H. Schedule H: Aging of All Claims.

4. Annual Financial Statements

Contractor shall submit to DHCS no later than 180 calendar days after the close of Contractor's fiscal year, annual financial reports. Contractor's annual financial reports shall be prepared on the DMHC required financial reporting forms and shall include, at a minimum, the following reports/schedules:

A. Jurat;

B. Report 1A and 1B: Balance Sheet;

C. Report 2: Statement of Revenue, Expenses, and Net Worth;

D. Statement of Cash Flow, prepared in accordance with Financial Accounting Standards Board Statement Number 95 (This statement is prepared in lieu of Report #3: Statement of Changes in Financial Position for GAAP compliance);

E. Report 4: Enrollment and Utilization Table;

F. Schedule F: Unpaid Claims Analysis;

G. appropriate footnote disclosures in accordance with GAAP; and

H. Schedule H: Aging of All Claims.

5. Annual Forecasts

Exhibit A, Attachment 2
Financial Information

Contractor shall submit to DHCS at least 60 days prior to the beginning of the FY, an annual forecast for the next FY.

Contractor's annual forecast shall be prepared on the DMHC required financial reporting forms and shall include, at a minimum, the following reports/schedules:

A. Report 2: Statement of Revenue, Expenses, and Net Worth by County. (Medi-Cal line of business);

B. Report 4: Enrollment and Utilization Table by County. (Medi-Cal line of business);

C. TNE (All lines of business); and

D. a detailed explanation of all underlying assumptions used to develop the forecast.

6. Compliance with Audit Requirements

Contractor shall cooperate with audits by DHCS, CMS, and any of their related entities or agents. Such audits may be waived, but is not required to be waived, by the auditing entity upon submission of the financial audit for the same period conducted by DMHC pursuant to Health and Safety Code section 1382.

7. Submittal of Financial Information

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

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

Exhibit A, Attachment 2
Financial Information

8. Fiscal Viability of Subcontracting Entities

Contractor shall maintain a system to evaluate and monitor the financial viability of all risk bearing subcontracting provider groups including, but not limited to, HMOs, independent Physician/provider associations (IPAs), medical groups, and Federally Qualified Health Centers (FQHCs).

9. Contractor's Obligations

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

Exhibit A, Attachment 3
Management Information System

1. Management Information System (MIS) Capability

A. Contractor's MIS shall have the capability to capture, edit, and utilize various data elements for both internal management use as well as to meet the data quality and timeliness requirements of DHCS's Encounter Data submission. All data related to this Contract shall be available to DHCS and to the Centers to Medicare and Medicaid Services (CMS) upon request. Contractor shall have and maintain a MIS that provides, at a minimum:

1. All Medi-Cal eligibility data;

2. Information of Members enrolled in Contractor's plan;

3. Provider claims status and payment data;

4. Health care services delivery Encounter Data;

5. Provider network information; and

6. Financial information as specified in Exhibit A, Attachment 1, Provision 8.

B. Contractor's MIS shall have processes that support the interactions between Financial, Member/Eligibility, Provider, Encounter Claims, Quality Management/Quality Improvement/Utilization; and Report Generation subsystems. The interactions of the subsystems must be compatible, efficient, and successful.

2. Encounter Data Submittal

A. Contractor shall implement policies and procedures for ensuring the complete, accurate, and timely submission of Encounter Data to DHCS, as defined in state and federal law and applicable DHCS APLs, for all items and services for which Contractor has incurred any financial liability furnished to a Member under this contract, whether directly or through subcontracts or other arrangements, including capitated providers. Encounter Data shall be submitted on at least a monthly basis in a form and manner specified by DHCS.

B. 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.

Exhibit A, Attachment 3
Management Information System

Contractor shall also have in place mechanisms, including edits and reporting systems sufficient to ensure Encounter Data is complete and accurate prior to submission to DHCS.

C. Contractor shall submit complete, timely, reasonable, and accurate Encounter Data on at least a monthly basis. DHCS will also allow Contractor to submit on a more frequent basis if preferable.

D. DHCS will measure the quality of the Encounter Data for completeness, timeliness, reasonability, and accuracy.

E. If DHCS finds deficiencies regarding Encounter Data or the quality of Encounter Data, DHCS may notify Contractor in writing of the deficiency and request correction and resubmission of the relevant Encounter Data. Contractor shall ensure that corrected data is resubmitted within 15 calendar days of the date of DHCS' notice. Upon Contractor's written request, DHCS may provide a written extension for submission of corrected Encounter Data.

3. MIS/Data Correspondence

Upon receipt of written notice by DHCS of any problems related to the submittal of data to DHCS, or any changes or clarifications related to Contractor's MIS system, Contractor shall submit to DHCS a CAP with measurable benchmarks within 30 calendar days from the date of the postmark of DHCS' written notice to Contractor. Within 30 calendar days of DHCS' receipt of CAP, DHCS shall approve the CAP or request revisions. Within 15 calendar days after receipt of a request for revisions to the CAP, Contractor shall submit a revised CAP for DHCS' approval. DHCS may continue to request revisions to the CAP until it is finally approved by DHCS, or until DHCS determines that Contractor is not acting in good faith to comply with the contract requirement to submit data. If contractor is not complying with the timelines identified in its approved CAP, contractor is not acting in good faith. If DHCS determines that Contractor is not acting in good faith to comply with the requirement to submit data, then DHCS may issue sanctions and/or terminate the contract as provided in Welfare & Institutions Code Section 14304.

4. Health Insurance Portability and Accountability Act (HIPAA)

Contractor shall comply with Exhibit G, Health Insurance Portability and Accountability Act (HIPAA) requirements, and all related federal and state regulations, as they become effective.

Exhibit A, Attachment 4
Quality Improvement System

1. General Requirement

Contractor shall implement an effective Quality Improvement System (QIS) in accordance with 42 CFR 460.32(a)(9), 460.130, 460.132, 460.134, 460.136, 460.138, and 460.140, and the standards in 28 CCR Section 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. Accountability

Contractor shall maintain a system of accountability which includes the participation of the governing body of Contractor's organization, the designation of a Quality Improvement Committee (QIC) with oversight and performance responsibility, the supervision of activities by the Medical Director, and the inclusion of employed or contracted Physicians and contracting providers in the process of QIS development and performance review. Participation of non-contracting providers is discretionary.

3. Governing Body

Contractor shall implement and maintain policies that specify the responsibilities of the governing body, in compliance with 42 CFR 460.62, and including, at a minimum, the following:

A. approves the overall QIS and the annual report of the QIS;

B. appoints an accountable entity or entities within Contractor's organization to provide oversight of the QIS;

C. routinely receives written progress reports from the QIS committee describing actions taken, progress in meeting QIS objectives, and improvements made; and

D. Directs the operational QIS to be modified on an ongoing basis and tracks all review findings for follow-up.

Exhibit A, Attachment 4
Quality Improvement System

4. Quality Improvement Committee

A. Contractor shall implement and maintain a QIC designated by and accountable to the governing body. The QIC shall be facilitated by the Medical Director or a Physician 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 SPDs and persons with chronic conditions (such as asthma, diabetes, and congestive heart failure), actively participate on the committee or medical sub-committee that reports to the QIC.

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

C. Contractor shall ensure that a summary of quality assurance activities are 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 the Members.

D. Contractor shall ensure that the Medical Director shall be directly involved in the implementation of Quality Improvement activities.

5. Provider Participation

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

B. Contractor shall maintain employment agreements and provider Contracts, which include a requirement securing cooperation with the QIS. Contractor shall ensure that contracted hospitals and other subcontractors shall allow Contractor access to the Medical Records of its Members.

Exhibit A, Attachment 4
Quality Improvement System

6. Delegation of Quality Improvement Activities

A. Contractor is accountable for QI functions and responsibilities even when it delegates QI activities to its subcontractors. Contractor shall maintain a system to ensure accountability of delegated QI activities including:

1) Maintenance of policies and procedures which describe: (i) delegated activities, (ii) QI authority, function, and responsibility, (iii) how each Subcontractor shall be informed of its scope of QI responsibilities, and (iv) Subcontractor's accountability for delegated activities;

2) Establish reporting standards to include findings and actions taken by the Subcontractor as a result of the QI activities with the reporting frequency to be at least quarterly;

3) Maintenance of written procedures and documentation of continuous monitoring of the delegated functions, evidencing that the quality of care being provided meets professionally-recognized standards;

4) Assurance and documentation that the Subcontractor has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities;

5) Contractor shall approve the delegate's QIS, including its policies and procedures, which shall meet standards set forth by Contractor; and

6) Contractor shall ensure that the quality of care being provided is continuously monitored and evaluated.

B. Contractor shall implement and maintain QI channels and facilitate coordination with other performance monitoring activities, including risk management and resolution and monitoring of Member grievances. Contractor's QIS shall maintain linkages with other management functions such as network changes, medical management systems (i.e. pre-certification), practice feedback to physicians, patient education/health education, Member services, human resources feedback, and cultural and linguistic services feedback.

Exhibit A, Attachment 4
Quality Improvement System

7. Written Description

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

A. The organizational commitment to the delivery of quality health care services as evidenced by goals and objectives which are approved by Contractor's governing body and periodically evaluated and updated.

B. The organizational chart evidencing key staff and the committees and bodies responsible for QI activities including reporting relationships of QIS committee(s) and staff within Contractor's organization.

C. The qualifications of staff responsible for QI studies and activities, including education, experience, and training.

D. A description of the system for provider review of QIS findings, which, at a minimum, demonstrates Physician and other appropriate professional involvement and includes provisions for providing feedback to staff and providers~~,~~ regarding QIS study outcomes.

E. The role, structure, and function of the QIC.

F. The processes and procedures designed to ensure that all Medically Necessary Covered Services are available and accessible to all Members regardless of sex, race, color, national origin, creed, ancestry, ethnic group identification, religion, age, gender, marital status, sexual orientation, health status, medical condition, mental disability, physical disability, or genetic information and that all Covered Services are provided in a culturally and linguistically appropriate manner.

G. A description of the mechanisms used to continuously review, evaluate, and improve access to and availability of services. The description shall include methods to ensure that members are able to obtain appointments within established standard.

H. A description of the quality of clinical care services provided, including, but not limited to, preventive services for adults, primary care, specialty, emergency, inpatient, and ancillary care services.

I. A description of the activities, including activities used by Members that are SPDs or persons with chronic conditions, designed to assure the provision of Case Management, coordination, and continuity of care

services. Such activities shall include, but are not limited to, those designed to assure availability and access to care, clinical services, and care management.

8. Quality Improvement Annual Report

Contractor shall develop an annual Quality Improvement Report (QIR) for submission to DHCS on an annual basis. The annual report shall include:

A. A comprehensive assessment of the QI activities undertaken and an evaluation of areas of success and needed improvements in services rendered within the QI program including, but not limited to, the collection of aggregate data on utilization; the review of quality of services rendered; and, outcomes/findings from Quality Improvement Projects (QIPs), consumer satisfaction surveys, and collaborative initiatives.

B. Copies of all final reports of non-governmental accrediting agencies (e.g. JCAHO, NCQA) relevant to Contractor's Medi-Cal line of business, including accreditation status and any deficiencies noted. Including the CAP, if any, developed to address noted deficiencies.

C. An assessment of Subcontractor's performance of delegated QI activities.

9. Systematic Process of Quality Improvement

A. Contractor's QIS shall objectively and systematically monitor and evaluate the quality and appropriateness of care and services rendered on an ongoing basis. Contractor shall implement a QIS that addresses the quality of clinical care as well as the quality of health services delivery. Contractor shall ensure that the studies described below reflect the population served in terms of age groups, disease categories, and special risk status. The QIS shall continuously monitor care against practice guidelines or clinical standards and shall use appropriate quality indicators as measurable variables. Contractor shall ensure that the data collected shall be analyzed by the appropriate health professionals, and system issues shall be addressed by the Interdisciplinary Team (IDT). Contractor shall undertake corrective actions within the time frames determined by DHCS whenever problems are identified. Contractor shall maintain a system for tracking the issues over time to ensure that actions for improvement are effective.

B. Contractor shall perform quality of care studies on an ongoing basis as listed below:

1) Clinical Areas

   a. Immunizations and health screens

   b. Adult preventive services

2) Health Services Delivery Areas

   a. Utilization of services

   b. Coordination of care

   c. Continuity of care

   d. Health education

   e. Emergency services

   f. Member satisfaction surveys

   g. Access to care

C. Contractor shall use the following standards and guidelines for adult preventive care based on guidelines contained in the Report of the United States Preventive Services Task Force. For quality of care studies in the health services delivery areas, Contractor shall use the specific standards set forth in the pertinent subsections. Contractor's Quality of Care studies may include health services delivery issues other than the priority areas identified. For other clinical or health services delivery areas where DHCS has not specified clinical standards or practice guidelines, Contractor shall submit these standards or guidelines to DHCS for approval six weeks prior to conducting the studies.

D. To the extent feasible and appropriate, Contractor shall use the most recent Health Plan Employer Data and Information Set (HEDIS) indicators for the required quality of care studies indicated in paragraph B.

10. Facility Review

A. Contractor shall conduct facility reviews on all service sites as part of the credentialing and recredentialing procedures. Facility reviews for medical specialty provider sites shall also be performed as follows:

Exhibit A, Attachment 4
Quality Improvement System

1) Upon receipt by Contractor of any complaint received from a Member regarding a medical specialty provider, after other means of communication (phone, email, etc.) have been unsuccessful for 10 business days;

2) At the site of the medical specialty provider set forth in the Member complaint; and

3) Within 15 business days of receipt by Contractor of the complaint.

B. Facilities used by Contractor for providing covered services shall comply with all applicable federal and state laws and regulations including, but not limited to, the provisions of Title 22, CCR, Section 53230.

C. Contractor shall ensure that its facility review procedures shall be submitted to DHCS for approval prior to use and shall comply with the current and/or revised requirements. These currently include the following categories:

1) Service and Provider Sites

a. Front office procedures including:

(1) Telephone access, triage, and advice

(2) Appointment scheduling, as well as a system for coordinating interpreters for Limited English Proficient (LEP) Members

(3) Missed appointment and follow-up

(4) Referral appointment and follow-up

(5) Referral (consultation) reports, lab and x-ray follow-up

b. Fire and disaster plan.

c. Infection control.

d. Handling of bio-hazardous wastes.

e. Health education.

f. Medical emergencies.

g. Pharmacy policies (including handling of sample drugs).

h. Medical Records storage and filing.

i. Medical Records documentation.

j. Grievances.

k. Laboratory services.

l. Radiological services.

m. Preventive services for adults.

n. Facility access for physically disabled individuals.

o. Informed consent procedures.

p. Linguistic services access.

2) Dental Provider Sites

Contractor shall develop, implement, and maintain a tool for monitoring dental providers and submit to DHCS for review and approval.

D. Contractor shall ensure that facility reviews are completed prior to new PACE Centers expansion. Contractor shall submit the results of PACE Centers expansion reviews to DHCS at least two weeks following the Licensing & Certification surveys and fire marshal clearance prior to plan or service site operation. For PACE Centers expansion reviews, Contractor shall submit an aggregate report of the review results.

E. Contractor shall provide any necessary assistance to DHCS in its conducting of Facility inspections and medical reviews of the quality of care being provided to Members. Contractor shall ensure correction of deficiencies as identified by those inspections and reviews according to the timeframes delineated by DHCS in the resulting reports.

F. Contractor shall ensure that sites with major, uncorrected deficiencies are not allowed to begin operation. Contractor shall take corrective action if a DHCS inspector finds a site to be in substantial non-compliance. Contractor shall require such site to cease providing services to Members, provided that such site may not be required to cease providing services in the event DHCS and Contractor agree to a plan of corrective action to be implemented by the site, and such plan is being implemented to the satisfaction of DHCS.

G. Contractor shall remain responsible for the oversight and monitoring of delegated facility review activities.

11. Credentialing and Recredentialing

Contractor shall develop and maintain written policies and procedures that include initial credentialing, recredentialing, recertification, and reappointment of physicians including Primary Care Physicians (PCPs) and specialists in accordance with DHCS All Plan Letter (APL) 19-004. Contractor shall ensure the policies and procedures are reviewed and approved by the governing body or designee. Contractor shall ensure the responsibility for recommendations regarding credentialing decisions will rest with a credentialing committee or other peer review body.

A. Standards

All providers of covered services must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified. All providers must be in good standing in the Medicare and Medicaid/Medi-Cal programs. Providers that have been terminated from either Medicare or Medicaid/Medi-Cal cannot participate in Contractor's provider network.

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

B. Delegated Credentialing

Contractor may delegate credentialing and recredentialing activities. If Contractor delegates these activities, Contractor shall comply with provision 6.

C. Credentialing Provider Organization Certification

Exhibit A, Attachment 4
Quality Improvement System

Contractor and their subcontractors (e.g. a medical group or independent Physician organization) may obtain credentialing provider organization certification (POC) from the National Committee on Quality Assurance (NCQA). Contractor may accept evidence of current NCQA POC certification in lieu of a monitoring visit at delegated physician organizations.

D. Disciplinary Actions

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

E. Medi-Cal and Medicare Provider Status

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. Terminated providers in either Medicare or Medi-Cal/Medicaid or on the Suspended and Ineligible Provider list~~;~~ cannot participate in Contractor's provider network.

Contractor to follow the requirements set forth in APL 16-001 https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2016/APL16-001.pdf

F. Health Plan Accreditation

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

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

G. Credentialing of Other Non-Physician Medical Practitioners

Exhibit A, Attachment 4
Quality Improvement System

Contractor shall develop and maintain policies and procedures that ensure that the credentials of nurse practitioners, clinical nurse specialists and physician assistants have been verified in accordance with state requirements applicable to the provider category.

12. Medical Records

A. General Requirement

Contractor shall ensure that appropriate medical records for Members, pursuant to Title 28, CCR, Section 1300.80(b)(4), Title 42 United States Code (USC) Section 1396a(w), 42 CFR 456.111 and 42 CFR 456.211, shall be available to health care providers at each encounter in accordance with Title 28, CCR Section 1300.67.1(c) and Title 22 CCR Section 53861, and Medi-Cal Managed Care Policy Letter 14-004.

B. Medical Records

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

1) For storage and filing of medical records, including: collection, processing, maintenance, storage, retrieval identification, retention, and distribution;

2) To ensure medical records are protected and confidential in accordance with all federal and state laws;

3) For release of information and obtaining consent for treatment; and

4) To ensure maintenance of medical records in a legible, current, detailed, organized and comprehensive manner (records may be electronic or paper copies).

C. On-Site Medical Record

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

D. Member Medical Record

Contractor shall ensure that a complete medical record is maintained for each Member in accordance with Title 22 CCR Section 53284, that

reflects all aspects of patient care, including ancillary services, and at a minimum includes:

1) Member identification on each page, with personal and/or biographical data in the record.

2) The identity of the Member's PCP.

3) All entries dated and author identified; For Member visits, the entries shall include, at a minimum, the subjective complaints, the objective findings, and the plan for diagnosis and treatment.

4) The record shall contain a problem list, a current medications list, a complete record of immunizations, and health maintenance or preventive services rendered.

5) Allergies and adverse reactions are prominently noted in the record.

6) All informed consent documentation, including the human sterilization consent procedures required by Title 22 CCR Sections 51305.1 through 51305.6, if applicable.

7) Reports of emergency care provided (directly by the contracted provider or through an emergency room) and the hospital discharge summaries for all hospital admissions.

8) Consultations, referrals, specialists', pathology, and laboratory reports. Any abnormal results shall have an explicit notation in the record.

9) Documentation of whether the individual has been informed and has executed an advanced directive such as a Durable Power of Attorney for Health Care.

10) Member’s preferred language (if other than English) or use of auxiliary aids and services for effective communication (Members with disabilities), prominently noted in the record as well as the request or refusal of language and/or interpretation services; and

11) Health education behavioral assessment and referrals to health education services.

Exhibit A, Attachment 4
Quality Improvement System

E. Contractor shall implement and maintain a system to review records for compliance with Medical Records standards, and institute a Corrective Action Plan when necessary. Contractor shall ensure that Medical Records shall be reviewed for:

1) uniformity of forms;

2) legibility (the record is legible to a person other than the writer);

3) completeness;

4) quality and appropriateness of services provided;

5) immunizations;

6) preventive health screening; and

7) authentication.

13. Laboratory Certification

A. To ensure that each laboratory used to perform services under this Contract or by subcontract complies with federal and State law, each location at which any test or examination on materials derived from the human body for the purpose of providing information for the diagnosis, prevention, treatment or assessment of any disease, impairment or health of a human being is performed shall have in effect:

1) A current, unrevoked or unsuspended certificate, certificate for provider-performed microscopy procedures, certificate of accreditation, certificate of registration or certificate of waiver issued under the requirements of 42 United States Code, Section 263a and the regulations adopted thereunder and found at 42 CFR, Part 493; and, either

a. A current, unrevoked or unsuspended license or registration issued under the requirements of Chapter 3 (commencing with Section 1200) of Division 2 of the California Business and Professions Code and the regulations adopted thereunder; or,

b. Be operated in conformity with Chapter 7 (commencing with Section 1000) of Division 1 of the California Health and Safety Code and the regulations adopted thereunder.

B. All places used to perform tests or examinations on human biological specimens (materials derived from the human body) are, by definition, "laboratories" under federal and state law.

C. Laboratories may exist, therefore, at nurses' stations within hospitals, clinics, skilled nursing facilities, operating rooms, surgical centers, Rural Health Clinics (RHCS), Physician offices, Planned Parenthood clinics, mobile labs, health fairs, and city, county or State labs.

D. Any laboratory that does not comply with appropriate federal and State law is not eligible for participation in, or reimbursement from, the Medicare, Medicaid, or Medi-Cal programs.

E. Member Dental Records

Contractor shall maintain a complete dental record and implement a system to review dental records, which at a minimum shall include:

1) Legible, organized, appropriately signed records.

a. Complete records with detailed findings;

b. Signed general and informed consent forms ;and

c. Complete treatment plan.

2) A medical history, current medications, allergies, and medical clearance if necessary.

Exhibit A, Attachment 5
Utilization Management

1. Utilization Management (UM) Program

Contractor shall develop, implement, and continually update and improve a UM program which ensures appropriate processes are used to review and approve the provision of medically necessary covered services. Contractor is responsible to ensure that the UM program includes:

A. Qualified staff who are responsible for the UM program.

B. The separation of medical decisions from fiscal and administrative management to assure those medical decisions will not be unduly influenced by fiscal and administrative management. Compensation of staff or Subcontractors that conduct UM activities shall not be structured to provide incentives to deny, limit, or discontinue Medically Necessary services.

C. Contractor shall ensure that the UM program allows for a second opinion from a qualified health professional at no cost to the Member.

D. Established criteria for approving, modifying, deferring, or denying requested services. Contractor shall utilize evaluation criteria and standards to approve, modify, defer, or deny services. Contractor shall document the manner in which providers are involved in the development and or adoption of the specific criteria used by the Contractor.

E. Contractor shall communicate to health care practitioners the procedures and services that require Prior Authorization and ensure that all contracting health care practitioners are aware of the procedures and timeframes necessary to obtain Prior Authorization for these services.

F. An established specialty referral system to track and monitor referrals requiring Prior Authorization through the Contractor. The system shall include authorized, denied, deferred, or modified referrals, and the timeliness for the referrals. This specialty referral system should include non-contracting providers.

   Contractor shall ensure that all contracting health care practitioners are aware of the referral processes and tracking procedures; and.

G. The integration of UM activities into the QIS, including a process to integrate reports on review of the number and types of appeals, denials, deferrals, and modifications to the appropriate QIS staff.

Exhibit A, Attachment 5
Utilization Management

These activities shall be done in accordance with Health and Safety Code section 1363.5 and California Code of Regulations, title 28, section 1300.70, subdivisions (b)(2)(H) & (c).

2. Prior-Authorization and Review Procedures

Contractor shall ensure that its prior-authorization, concurrent review, and retrospective review procedures meet the following minimum requirements:

A. Consult with the requesting Provider for medical services, when appropriate.

Decisions to deny or to authorize an amount, duration, or scope that is less than requested shall be made by a qualified health care professional with appropriate clinical expertise in treating the medical or behavioral health condition or disease. Appropriate clinical expertise may be demonstrated by appropriate specialty training, experience, or certification by the American Board of Medical Specialties. Qualified health care professionals do not have to be an expert in all conditions and may use other resources to make appropriate decisions.

B. Qualified health care professionals supervise review decisions, including service reductions, and a qualified Physician will review all denials that are made, in whole or in part, on the basis of Medical Necessity. For purposes of this provision, a qualified physician or Contractor's pharmacist may approve, defer, modify, or deny prior authorizations for pharmaceutical services, provided that such determinations are made under the auspices of, and pursuant to, criteria established by Contractor's medical director.

C. There is a set of written criteria or guidelines for Utilization Review that is based on sound medical evidence, is consistently applied**,** regularly reviewed, and updated.

D. The reasons for decisions are clearly documented.

E. Notification to Members regarding denied, deferred or modified referrals is made as specified in Exhibit A, Attachment 13. There shall be a well-publicized appeals procedure for both providers and patients.

F. Decisions and appeals are made in a timely manner and are not unduly delayed for medical conditions requiring time-sensitive services.

G. Prior Authorization requirements shall not be applied to emergency services, preventive services, sexually transmitted disease services, and HIV testing.

H. Records, including any notice of action (NOA), shall meet the retention requirements described in Exhibit E, Attachment 2, provision 19, Audit.

I. Contractor must notify the requesting provider or Member of any decision to deny, approve, modify, or delay a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the provider may be provided orally or in writing. Notice to the member shall be in writing and in accordance with the requirements in Exhibit A, Attachment 13, Member Services, Provision 6, Denial, Deferral, or Modification of Prior Authorization Requests.

3. Timeframes and Medical Authorization

A. Emergency Care & Post-Stabilization: contractor must comply with the timeframes and authorization procedures set forth in 42 CFR 460.100, which are set forth in Exhibit A, Attachment 8, Provision 11.

B. Non-urgent care following an exam in the emergency room: response to request within one hour or it will be deemed approved.

C. Concurrent review of authorization for treatment regimen already in place: within five working days or less, consistent with the urgency of the Member's medical condition and in accordance with Health and Safety Code section 1367.01(h)(3), or any future amendments thereto.

D. Retrospective review: within 30 calendar days in accordance with Health and Safety Code section 1367.01(h)(1), or any future amendments thereto.

E. Pharmaceuticals: for all covered outpatient drug Prior Authorization requests, provide notice by telephone, fax, email or other electronic communication within 24 hours of receipt of the request, and in emergency situations dispense at least a 72-hour supply of the covered outpatient drug in accordance with Welfare and Institutions Code section 14185, 42 CFR 438.3(s)(6), and Section 1927(d)(5)(A) of the Social Security Act or any future respective amendments thereto.

F. Routine Authorizations: within five working days from receipt of the information reasonably necessary to render a decision (these are requests

for specialty service, cost control purposes, out-of-network not otherwise exempt from Prior Authorization) in accordance with Health and Safety Code, section 1367.01, 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.

G. Expedited Authorizations: For requests in which a provider indicates, or the Contractor determines that, following the standard timeframe could seriously jeopardize the Member's life, 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 not later than 72 hours after receipt of the request for services. The Contractor may extend the three working days time period by up to 14 calendar days if the Member requests an extension, or if the Contractor justifies to satisfaction of DHCS the need for additional information and how the extension is in the Member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.

H. Hospice Inpatient Care: 24-hour response.

4. Review of Utilization Data

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

5. Delegating UM Activities

Contractor may delegate UM activities. If Contractor delegates these activities, Contractor shall comply with Exhibit A, Attachment 4, Provision 6.

Exhibit A, Attachment 6
Provider Network

1. Network Composition

Contractor shall demonstrate the continuous availability and accessibility of adequate numbers of institutional facilities, service locations, service sites, and professional, allied, and supportive paramedical personnel and providers to provide covered services including the provision of all medical care necessary under emergency circumstances on a 24 hour, seven days-per week basis.

Contractor shall ensure and monitor an appropriate provider network, including PCPs, specialists, professional, allied, supportive paramedical personnel, and an adequate number of accessible inpatient facilities and PACE Centers within each service area.

2. Provider to Member Ratios

Contractor shall ensure that networks continuously satisfy the following full-time equivalent provider to Member ratios:
One full-time equivalent PCP per 350 Members.

3. Physician Supervisor to Non-Physician Medical Practitioner Ratios

Contractor shall ensure compliance with Title 22 CCR Sections 51240 and 51241, and that full time equivalent physician supervisor to non-physician medical practitioner ratios at PACE Centers do not exceed the following:

A. nurse practitioners 1:4

B. physician assistants 1:2

C. four non-physician medical practitioners in any combination that does not include more than two physician assistants.

4. Emergency Services

Contractor shall have, as a minimum, a designated emergency service facility, providing care on a 24 hours a day, seven days-per-week basis. This designated emergency service facility will have one or more Physicians and one or more nurses on duty in the facility at all times.

5. Specialists

Contractor shall maintain adequate numbers and types of specialists within their network to accommodate the need for specialty care in accordance with Welfare

and Institutions Code section 14182(c), criteria (2). Contractor shall provide a recording/tracking mechanism for each authorized, denied, or modified referral. In addition, Contractor shall offer second opinions by specialists to any Member upon request.

6. Federally Qualified Health Center (FQHC) Services

Contractor shall meet federal requirements for access to FQHC services, including those in 42 United States Code section 1396b(m). Contractor shall reimburse FQHCs in accordance with Exhibit A, Attachment 8, Provision 5.

7. Physician Services

Contractor shall provide physician services directly through physicians who are employees of Contractor or who have agreements with Contractor to provide health care services or who are providers of unusual or seldom-used health care services as defined by DHCS.

8. Continuity of Care

Contractor shall establish and operate a system to assure continuity of care through appropriate referral of Members needing specialty health care services, documentation of referral services in Member medical records, monitoring of Members with ongoing medical conditions, documentation of Member emergency medical encounters in medical records, with appropriate follow-up as medically indicated, and coordinated hospital discharge planning that includes necessary post-discharge care.

9. Emergency Management Plan

Contractor shall maintain an emergency management plan in compliance with 42 CFR 460.84, including a response and recovery approach that provides for the mitigation, response to, and recovery from an emergency.

10. Plan Physician Availability

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

11. Plan Subcontractors

Exhibit A, Attachment 6
Provider Network

Contractor shall submit to DHCS, a quarterly updated subcontractor listing, which, at a minimum, contains the following information:

A. Headers to indicate city or region names (in alphabetical order);

B. Specialty (e.g. Optometry);

C. Provider's name (last, first-listed alphabetically);

D. Street address;

E. City including zip codes;

F. Telephone number including area code;

G. Languages (other than English) spoken at the provider site; and

H. Medical Group/Institutional/Specialty name (e.g. University of California).

Contractor shall notify DHCS in the event the agreement with the Subcontractor is amended or terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached.

12. 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.

13. Subcontracts

Contractor may enter into subcontracts with other entities in order to fulfill the obligations of the Contract. Contractor shall evaluate the prospective Subcontractor's ability to perform the subcontracted services, shall oversee and remain accountable for any functions and responsibilities delegated and shall meet the subcontracting requirements as stated in 42 CFR 460.70(a), (b), (c), and (d).

A. Subcontract Requirements

Exhibit A, Attachment 6
Provider Network

Each subcontract as defined in Exhibit E, Attachment 1, shall contain:

1) Specification of the services to be provided by the subcontractor;

2) Specification that the Subcontract shall be governed by and construed in accordance with all laws and applicable regulations governing this Contract;

3) Specification that the Subcontract or Subcontract amendments shall become effective only as set forth in paragraph C;

4) Specification of the term of the Subcontract, including the beginning and ending dates as well as methods of extension, renegotiation, and termination;

5) Language comparable to Exhibit A, Attachment 8, provision 7 for those Subcontractors at risk for non-contracting emergency services;

6) Subcontractor's agreement to submit reports as required by Contractor;

7) Specification that the Subcontractor shall comply with all monitoring provisions of this Contract and any monitoring requests by DHCS;

8) Subcontractor's agreement to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of the subcontract, available for the purpose of an audit, evaluation, inspection, examination, or copying, including but not limited to access requirements and state's right to monitor, as set forth in Exhibit E, Attachment 2, provision 20:

    a. By DHCS, CMS, Department of Health and Human Services (DHHS), and Department of Justice (DOJ), DMHC or their designees.

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

c. In a form maintained in accordance with the general standards applicable to such book or record keeping.

d. For a term of at least ten years from the close of the current fiscal year in which the service occurred; in which the record or data was created or applied; and for which the financial record was created.

e. Including all encounter data for a period of at least ten years.

f. If DHCS, CMS, or the Department of Health and Human Services (DHHS) Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Subcontractor at any time, and

g. Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Subcontractor from participation in the Medi-Cal program; seek recovery of payments made to the Subcontractor.

9) Full disclosure of the method and amount of compensation or other consideration to be received by the Subcontractor from Contractor.

10) Subcontractor's agreement to maintain and to 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 Subcontractor:

a. Make all premises, facilities, equipment, applicable books and records, contracts, computer, or other electronic systems related to this Contract, available at all reasonable times for audit, inspection, examination or copying by DHCS, DHHS, CMS, DOJ, or their designees.

b. Retain all records and documents for a minimum of ten years from the final date of the Contract period or from the date of completion of any audit, whichever is later.

11) Subcontractor's agreement to assist Contractor in the transfer of care pursuant to Exhibit E, Attachment 2, provision 15 B, subparagraph B in the event of Contract termination.

12) Subcontractor's agreement to assist Contractor and DHCS in the transfer of care in the event of Sub-contract termination for any reason.

13) Subcontractor's agreement that assignment or delegation of the subcontract shall be void unless prior written approval is obtained from DHCS.

14) Subcontractor's agreement to hold harmless both the state and Members in the event Contractor cannot or will not pay for services performed by the Subcontractor pursuant to the subcontract.

15) Subcontractor's agreement to timely gather, preserve and provide to DHCS, any records in the Subcontractor's possession, in accordance with Exhibit E, Attachment 2, provision 25.

16) Subcontractor's agreement to provide interpreter services for Members at all provider sites.

17) Subcontractor's right to submit a grievance and Contractor's formal process to resolve provider grievances.

18) Subcontractor's agreement to participate and cooperate in Contractor's QIS.

19) If Contractor delegates QI activities, subcontract shall include those provisions stipulated in Exhibit A, Attachment 4, provision 6; and

20) Subcontractor's agreement to comply with all applicable requirements of DHCS, Medi-Cal Managed Care Program, and the Integrated Systems of Care Division (ISCD).

B. Department Approval

1) Except as provided in Exhibit A, Attachment 8, provision 7, regarding FQHCs and RHCS, a provider subcontract entered into by a Contractor which is not a federally qualified HMO shall become effective upon approval by DHCS in writing or by operation of law where DHCS has acknowledged receipt of the proposed subcontract, and has failed to approve or disapprove the proposed subcontract within sixty (60) days of receipt. Within five (5) State working days of receipt, DHCS shall acknowledge verbally or in

writing the receipt of any material sent to DHCS by Contractor for approval.

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

3) Whenever contractor submits a subcontract or amendment to a subcontract to DHCS, contractor must identify where specifically in the subcontract each requirement of 42 CFR 460.70(a), (b), (c), and (d) are met.

C. Public Records

Subcontracts entered into by 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 5 percent of the stock issued by the Subcontractor and major creditors holding more than 5 percent of the Subcontractor's debt will be attached to the subcontract at the time it is presented to DHCS.

14. Restrictions on Delegation

Existing and applicant PACE Organizations (POs) are not allowed to delegate to a separate entity the operation of an existing or additional (expansion) PACE Center and IDT. DHCS reserves the right to determine whether a PO delegation arrangement involves a separate entity. If DHCS determines that the delegation arrangement involves a separate entity, DHCS may terminate the contract or take other appropriate action, including but not limited to requiring the PO to comply with a CAP. POs may subcontract for the provision of member service(s), as determined necessary by the IDT, to ensure that all services necessary to maintain a member safely in their home/community are available to the member.

Exhibit A, Attachment 6
Provider Network

The only exception to the prohibition on the delegation of PACE Center and IDT operations is the On Lok delegation contract with the Institute of Aging originally established on August 1, 1996.

The prohibition on delegation does not prohibit a PO from utilizing alternative care settings (ACS). An ACS is any physical location in the POs approved service area other than the member home, an inpatient facility, or PACE Center. A PACE member may receive some (but not all) PACE Center services at an ACS on a fixed basis during usual and customary PACE center hours of operation. An ACS cannot replace a PACE Center, and all PACE members receiving services at an ACS must be assigned to a PACE Center and IDT.

15. Subcontracts with Federally Qualified Health Centers and Rural Health Clinics

Subcontracts with FQHCs shall also meet Subcontract requirements of provision 13 above and reimbursement requirements in Exhibit A, Attachment 8, provision 7.

16. Nondiscrimination in Provider Contracts

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

Exhibit A, Attachment 7
Provider Relations

1. Exclusivity

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

2. Provider Appeals

Contractor shall have a formal process to accept, acknowledge, and resolve Provider Appeals. A provider of medical services may submit to Contractor an appeal concerning the authorization or denial of a service; denial, deferral or modification of a Prior Authorization request on behalf of a Member; or the processing of a payment or non-payment of a claim by the Contractor. This process shall be communicated to all contracting, subcontracting, and non-contracting providers.

Contractor shall implement and maintain procedures to monitor Providers' Appeals, which shall include:

A. A procedure to ensure timely resolution and feedback to provider. Contractor shall acknowledge receipt of the Appeal within five days and resolve the Appeal within 30 days or document reasonable efforts to resolve the Appeal.

B. A procedure for systematic aggregation and analysis of the Appeals data and use for Quality Improvement.

C. A procedure to ensure that the Appeal submitted is reported to an appropriate level, i.e., payment or administrative issues versus medical or health care delivery issues.

3. Non-Contracting, Non-Emergency Provider Communication

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

4. Provider Manual

Contractor shall issue a provider manual and updates to the contracting and subcontracting providers of Medi-Cal services. That includes information and updates regarding covered services, policies and procedures, statutes,

regulations, telephone access, special requirements, and the Member grievance, appeal, and State Hearing process. The Contractor's provider manual shall include the following Member rights information:

A. member's right to a State Hearing, how to obtain a hearing, and representation rules at a State Hearing;

B. member's right to file Grievances and Appeals as well as their requirements and timeframes for filing;

C. availability of assistance in filing;

D. toll-free numbers to file oral Grievances and Appeals; and

E. member's right to request continuation of benefits during an appeal or State Hearing.

5. Provider Training

A. Contractor shall ensure that all Providers receive training regarding the PACE 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 PACE 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 prior to commencement of Provider service with participant. Contractor shall ensure that Provider training includes information on all Member rights specified in Exhibit A, Attachment 13, including the right to full disclosure of health care information and the right to actively participate in health care decisions. Contractor shall ensure that ongoing training is conducted when deemed necessary by either the Contractor or the state.

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

Exhibit A, Attachment 7
Provider Relations

6. Emergency Preparedness

A. Contractor shall establish and annually update an emergency preparedness program that meets all federal, state and local emergency preparedness requirements and complies with 42 CFR 460.84. Without limitation, Contractor shall do all of the following:

1) Contractor shall develop and annually update an emergency preparedness plan, in compliance with 42 CFR 460.84(a), that is based on a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.

2) Contractor shall develop and annually update documented policies and procedures, in compliance with 42 CFR 460.84(b), to manage medical and nonmedical emergencies and disasters identified in its emergency plan.

3) Contractor shall ensure that unexpired food, water, medical supplies, and functioning emergency equipment, including easily portable oxygen, airways, suction, and emergency drugs, along with employees who know how to use the equipment, are on the premise of every service site at all times and readily available.

4) Contractor shall develop and annually update a communication plan in compliance with 42 CFR 460.84(c).

5) Contractor shall provide initial and annual emergency preparedness training and orientation to all its employees, contracted providers, Members, and others, as required by 42 CFR 460.84(d), and shall ensure that staff demonstrate a knowledge of emergency procedures, including informing Members what to do, where to go, and whom to contact in case of an emergency. Contractor shall maintain documentation of all training; and.

6) Contractor shall conduct exercises to test, evaluate, and document the effectiveness of its emergency plan at least annually, in compliance with 42 CFR 460.84(d).

B. If Contractor is part of a health care system consisting of multiple separately certified health care facilities that elect to have a unified and integrated emergency preparedness program, Contractor must ensure compliance with 42 CFR 460.84(e).

Exhibit A, Attachment 7
Provider Relations

C. Protocols shall be distributed to all Contractor's employees and contracted providers in the service area and shall include, at a minimum, the following:

1) description of telephone access, triage, and advice systems used by Contractor;

2) a plan contact person or an on-call provider responsible for coordinating services that can be accessed 24 hours per day:

3) process for rapid interfacing with emergency care systems; and

4) referral procedures (including after-hours instructions) which emergency department personnel can provide to Medi-Cal Members who present at an emergency department for non-emergency services.

D. Contractor shall ensure that the federal government, State, and Members are held harmless if Contractor does not pay for emergency services.

E. Contractor shall test, evaluate, and document the effectiveness of its emergency and disaster plans at least annually.

7. Prohibited Punitive Action Against the Provider

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

Exhibit A, Attachment 8
Provider Compensation Arrangements

1. Compensation

Contractor may compensate providers as Contractor and provider negotiate and agree. Unless DHCS objects, compensation may be determined by a percentage of the Contractor's payment from DHCS. This provision shall not be construed to prohibit Subcontracts in which compensation or other consideration is determined to be on a Capitation basis.

2. Physician Incentive Plan Requirements

Contractor may implement and maintain a physician incentive plan only if no specific payment is made directly or indirectly under the incentive plan to a physician or physician group as an inducement to reduce or limit Medically Necessary Covered Services provided to an individual Member.

3. Claims Processing

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

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

B. Contractor shall pay 90% of Complete Claims from practitioners who are in individual or group practices or who participate in health facilities, within 30 days of the date of receipt and 99 percent of all Complete Claims within 90 days. The date of receipt shall be the date Contractor receives the claim, as indicated by its date stamp on the claim. The date of payment shall be the date of the check or other form of payment.

C. Contractor shall maintain procedures for pre-payment and post-payment claims review, including review of data related to provider, Member and Covered Services for which payment is claimed.

D. Contractor shall maintain sufficient claims processing/tracking/payment systems capability to: comply with applicable federal and state law and regulations and Contract requirements, determine the status of received claims, and calculate the estimate for incurred and unreported claims, as specified by Title 28, CCR, Sections 1300.77.1 and 1300.77.2.

Exhibit A, Attachment 8
Provider Compensation Arrangements

4. Prohibited Claims

A. Except in specified circumstances, Contractor and any of its affiliates and subcontractors shall not submit a claim or demand, or otherwise collect reimbursement for any services provided under this Contract to a Medi-Cal Member. Collection of claim may be made under those circumstances described in Welfare and Institutions Code section 14452.6, Title 22, CCR, sections 53220, and 53222.

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

5. Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), and Indian Health Programs

A. FQHCs Availability and Reimbursement Requirement

If FQHC or RHC services are not available in the Contractor's provider network Contractor shall reimburse non-contracting FQHCs and RHCs for services provided to Contractor's Members at a level and amount of payment that is not less than the Contractor makes for the same scope of services furnished by a provider that is not a FQHC or RHC.

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

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

consistent with the provisions of Welfare and Institutions Code, Section 14087.325(h).

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

C. Indian Health Programs

Contractor shall reimburse Indian Health Programs for services provided to Members who are qualified to receive services from an Indian Health Program as set forth in 42 USC Section 1396u-2(h)(2), Section 5006 of Title V of the American Recovery and Reinvestment Act of 2009, and, insofar as they do not conflict with Federal law or regulations, the reimbursement options set forth in Title 22 CCR Section 55140(a).

6. Sexually Transmitted Disease (STD)

Contractor shall reimburse Local Health Departments (LDHs) and non-contracting family planning providers at no less than the appropriate Medi-Cal Fee For Service (FFS) rate, for the diagnosis and treatment of a STD episode, as defined in Medi-Cal Managed Care Policy Letter No. 96-09. Contractor shall provide reimbursement only if STD treatment providers provide treatment records or documentation of the Member's refusal to release Medical Records to Contractor along with billing information.

7. HIV Testing and Counseling

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

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

A. Emergency Services: Contractor is responsible for coverage and payment of emergency services and post stabilization care services and must cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the plan. Contractor may not deny payment for treatment obtained when an enrollee had an Emergency Medical Condition, including cases in which the absence of immediate

medical attention would not have had the outcomes specified in 42 CFR 438.114 (a) of the definition of Emergency Medical Condition. Further, Contractor may not deny payment for treatment obtained when a representative of Contractor instructs the enrollee to seek Emergency Services.

B. Contractor may not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms or refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the enrollees Primary Care Provider (PCP), the plan, or DHCS of the enrollee's screening and treatment within ten calendar days of presentation for emergency services. A Member who has an Emergency Medical Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or to stabilize the patient.

C. Contractor shall pay for Emergency Services received by a Member from non-contracting providers. Payments to non-contracting providers shall be for the treatment of the Emergency Medical Condition, including Medically Necessary inpatient services rendered to a Member until the Member's condition has stabilized sufficiently to permit referral and transfer in accordance with instructions from Contractor, or the Member is stabilized sufficiently to permit discharge. The attending emergency Physician, or the provider treating the Member is responsible for determining when the Member is sufficiently stabilized for transfer or discharge and that determination is binding on the Contractor. Emergency Services shall not be subject to Prior Authorization by Contractor.

D. At a minimum, Contractor must reimburse the non-contracting emergency department and, if applicable, its affiliated providers for Physician services at the lowest level of emergency department evaluation and management Physician's Current Procedural Terminology (CPT) codes, unless a higher level is clearly supported by documentation, and for the facility fee and diagnostic services such as laboratory and radiology.

E. For all non-contracting providers, reimbursement by Contractor, or by a subcontractor who is at risk for out-of-plan Emergency Services, for properly documented claims for services rendered on or after January 1, 2007 by a non-contracting provider pursuant to this provision shall be made in accordance with provision 3 above, and Title 42 U.S.C. Section 1396u-2(b)(2)(D).

Exhibit A, Attachment 8
Provider Compensation Arrangements

F. In accordance with Title 28, CCR, section 1300.71.4, Contractor shall approve or disapprove a request for post-stabilization inpatient services made by a non-contracting provider on behalf of a Member within 30 minutes of the request. If Contractor fails to approve or disapprove authorization within the required timeframe, the authorization will be deemed approved. Contractor is financially responsible for post-stabilization service payment as provided in sub-provision C above.

G. 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 Title 22, CCR, section 53620 et. seq., except Section 53698. Contractor agrees to abide by the findings of DHCS in such cases, to promptly reimburse the non-contracting provider within 30 calendar days of the effective date of a decision that Contractor is liable for payment of a claim and to provide proof of reimbursement in such form as the DHCS Director may require. Failure to reimburse the non-contracting provider and provide proof of reimbursement to DHCS within 30 calendar days shall result in liability offsets in accordance with Welfare and Institutions Code sections 14454(c) and 14115.5, and Title 22, CCR, Section 53702.

H. Post Stabilization Services: Post-stabilization care means services provided subsequent to an emergency that a treating physician views as medically necessary after an Emergency Medical Condition has been stabilized. They are not emergency services, which Contractor is obligated to cover. Rather, they are non-emergency services that Contractor should approve before they are provided outside of the PACE plan. Contractor must establish and maintain a written plan which provides for coverage of urgently needed out-of-network and post-stabilization care services when either of the following conditions is met:

1) the services are preapproved by the PACE organization; or

2) the services are not preapproved by the PACE organization because the PACE organization did not respond to a request for approval within one hour after being contacted or cannot be contacted for approval.

Post stabilization care services are covered and paid for in accordance with provisions set forth at 42 CFR,422.113(c). Contractor is financially responsible for post-stabilization services obtained within or outside Contractor's network that are pre-approved by a plan provider or other

entity representative. Contractor is financially responsible for post-stabilization care services obtained within or outside Contractor's network that are not pre-approved by a plan provider or other Contractor representative, but administered to maintain the enrollee's stabilized condition within one hour of a request to Contractor for pre-approval of further post-stabilization care services.

I. Contractor is also financially responsible for post-stabilization care services obtained within or outside Contractor's network that are not pre-approved by a plan provider or other entity representative, but administered to maintain, improve or resolve the enrollee's stabilized condition if Contractor does not respond to a request for pre-approval within 30 minutes; Contractor cannot be contacted; or Contractor's representative and the treating Physician cannot reach an agreement concerning the enrollee's care and a plan Physician is not available for consultation. In this situation, Contractor must give the treating Physician an opportunity to consult with a plan Physician and the treating Physician may continue with care of the patient until a plan Physician is reached or one of the criteria of 42 CRF, 422.113(c)(3) is met.

J. Contractor's financial responsibility for post-stabilization care services it has not pre-approved ends when a plan Physician with privileges at the treating hospital assumes responsibility for the Member's care, a plan Physician assumes responsibility for the Member's care through transfer, a plan representative and the treating Physician reach an agreement concerning the enrollee's care, or the enrollee is discharged.

K. Consistent with 42 CFR, sections 438.114(e), 422.113(c)(2), and 422.214, Contractor is financially responsible for payment for post-stabilization services following an emergency admission at the hospital's Medicare rate if the member is Medicare eligible or at the hospital's Medi-Cal FFS payment amounts if the member is eligible for Medi-Cal only for general acute care inpatient services rendered by a non-contracting hospital, unless a lower rate is agreed to in writing and signed by the hospital.

1) For the purposes of this Paragraph L, the Medi-Cal payment amount for dates of service when the post-stabilization services were rendered shall be in the Medi-Cal payment amounts that are:

a) Published in the annual All Plan Letter issued by the Department in accordance with California Welfare and Institutions Code section 14091.3, which for the purposes of this Paragraph L shall apply to all acute care hospitals,

including hospitals contracting with the State under the Medi-Cal Selective Provider Contracting Program (Welf. & Inst. Code, § 14081 et seq.), less any associated direct or indirect medical education payments to the extent applicable, which Item (a) shall be applicable until it is replaced by the implementation of the payment methodology in Item (b) below.

b) Established in Welfare and Institutions Code section 14105.28, upon the Department's implementation of the payment methodology based on diagnosis-related groups, which for the purposes of this Paragraph K shall apply to all acute care hospitals, including public hospitals that are reimbursed under the Certified Public Expenditure (CPE) Basis methodology (Welf. and Inst. Code § 14166. et. seq.), less any associated direct or indirect medical education payments to the extent applicable.

2) Payment made by Contractor to a hospital that accurately reflects the payment amounts required by this provision shall constitute payment in full under this Paragraph L, and shall not be subject to subsequent adjustments or reconciliations by Contractor, except as provided by Medicaid and Medi-Cal law and regulations. A hospital's tentative and final cost settlement processes required by California Code of Regulations section 51536 shall not have any effect on payments made by Contractor pursuant to this paragraph L.

Exhibit A, Attachment 9
Access and Availability

1. General Requirement

A. Contractor shall establish and implement a written plan to furnish care that meets the needs of each member in all care settings 24 hours a day, every day of the year. Contractor shall furnish comprehensive medical, health, and social services that integrate acute and long-term care.

B. The PACE benefit package for all members includes the following:

1) all Medicare-covered items and services;

2) all Medicaid-covered items and services, as specified in the State's approved Medicaid plan; and

3) other services determined necessary by the interdisciplinary team to improve and maintain the member's overall health status.

C. While enrolled in the Contractor's PACE plan, the member must receive Medi-Cal benefits solely through Contractor's PACE organization. Medicaid benefit limitations and conditions relating to amount, duration, scope of services, deductibles copayments, coinsurance, or other cost-sharing do not apply.

D. Contractor must operate at least one PACE center either in, or contiguous to, it's defined service area with sufficient capacity to allow routine attendance by members. The PACE Center must comply with the physical environment requirements of 42 CFR 460.72.

E. Contractor must ensure accessible and adequate services to meet the needs of its members. If necessary, Contractor must increase the number of PACE centers, staff, or other PACE services.

F. If Contractor operates more than one center, each PACE center must offer the full range of services and have sufficient staff to meet the needs of members.

G. At a minimum, the following services must be furnished at each PACE center:

a. Primary care, including physician and nursing services;

b. Social services;

Exhibit A, Attachment 9
Access and Availability

c. Restorative therapies, including physical therapy and; occupational therapy;

d. Personal care and supportive services;

e. Nutritional counseling;

f. Recreational therapy; and

g. Meals.

H. Contractor shall ensure that each Member has PCP who is available for sufficient time to ensure access for the assigned Member upon request by the Member or when medically required and to ensure case management of the Member on an on-going basis. This requirement does not preclude an appropriately licensed professional from being a substitute for the PCP in the event of vacation, illness or other unforeseen circumstances.

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

J. Contractor shall ensure that telehealth is recognized as a legitimate means by which a member may receive health care services from a health care provider without in-person contact with the health care provider, pursuant to the provisions of Welfare and Institutions Code section 14594.

a. Contractor shall not require that in-person contact occur between a health care provider and a patient before payment is made for the covered services appropriately provided through telehealth, subject to the terms and conditions of the contract entered into between the enrollee or subscriber and Contractor, and between Contractor and its participating providers or provider groups.

b. Contractor shall not limit the type of setting where services are provided for the patient or by the health care provider before payment is made for the covered services appropriately provided through telehealth, subject to the terms and contract entered into between the enrollee or subscriber and the PACE organization, and between the PACE organization and its participating providers or provider groups.

c. Contractor may not require the use of telehealth when the health care provider has determined that it is not appropriate.

2. Access Requirements

Contractor shall establish acceptable accessibility requirements in accordance with Title 28 CCR Section 1300.67.2.1 and as specified below. DHCS will review and approve requirements for reasonableness. Contractor shall communicate, enforce, and monitor providers' compliance with these requirements.

A. Appointments

Contractor shall implement and maintain procedures for Members to obtain appointments for routine care, Urgent Care, routine specialty referral appointments, emergency care, adult Initial Health Assessments (IHAs), and procedures for obtaining appointments with specialists. For purposes of this provision, "Urgent Care" means "on-site" Urgent Care**.** Contractor shall also include procedures for follow-up on missed appointments.

B. Urgent Care

Contractor shall ensure that a Member needing Urgent Care shall be seen within 24 hours upon request. For purposes of this provision, "Urgent Care" means "on-site" Urgent Care.

C. Waiting Times

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

D. Telephone Procedures

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

E. After Hours Calls

Exhibit A, Attachment 9
Access and Availability

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

F. Sensitive Services

Contractor shall implement and maintain procedures to ensure confidential access in a timely manner to Sensitive Services without Prior Authorization for all Members.

1) Sexually Transmitted Diseases (STDs)

Contractor shall provide access to STD services without Prior Authorization to all Members both within and outside its provider network. Members may access out-of-plan STD services through LHD clinics, family planning clinics or through other community STD service providers. Members may access LHD clinics and family planning clinics for diagnosis and treatment of a STD episode.

2) HIV Testing and Counseling

a. Members may access confidential HIV counseling and testing services through the Contractor's provider network and through out-of-network local LHD and family planning providers.

b. Contractor shall develop, implement and maintain policies and procedures for the treatment of HIV infection and AIDS. Contractor shall submit any changes in these policies and procedures to DHCS at least 30 days prior to their implementation.

G. 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.

H. Unusual Specialty Services

Exhibit A, Attachment 9
Access and Availability

Contractor shall arrange for the provision of Unusual Specialty Services from specialists outside the network if unavailable within Contractor's network, when it is determined medically necessary.

3. Emergency Care

Contractor shall establish and maintain a written plan to handle emergency care as required by 42 CFR 460.100. The plan must ensure that CMS, the State, and PACE members are held harmless if Contractor does not pay for emergency services.

Emergency care is appropriate when services are needed immediately because of an injury or sudden illness and the time required to reach Contractor or one of its contract providers, would cause risk of permanent damage to the member's health. Emergency services include inpatient and outpatient services that meet the following requirements:

A. Are furnished by a qualified emergency services provider, other than the Contractor or one of its contract providers, either in or out of the Contractor's service area;

B. Are needed to evaluate or stabilize an emergency medical condition. An emergency medical condition means a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

1) Serious jeopardy to the health of the member;

2) Serious impairment to bodily functions;

3) Serious dysfunction of any bodily organ or part.

Contractor must ensure that the member or caregiver, or both, understand when and how to get access to emergency services and that no prior authorization is needed.

Contractor must provide for the following:

1. An on-call provider, available 24–hours per day to address member questions about emergency services and respond to requests for

authorization of urgently needed out-of-network services and post stabilization care services following emergency services.

2. Coverage of urgently needed out-of-network and post-stabilization care services when either of the following conditions are met:

   a. The services are preapproved by Contractor; and

   b. The services are not preapproved by Contractor because Contractor did not respond to a request for approval within 1 hour after being contacted or cannot be contacted for approval.

C. Contractor shall cover Emergency Medical Services without Prior Authorization pursuant to California Code of Regulations title 28 section 1300.67(g), and section 53216. Contractor shall coordinate access to emergency care services in accordance with the Contractor's DHCS-approved emergency department protocol (see Exhibit A, Attachment 7).

D. Contractor shall ensure adequate follow-up care for those Members who have been screened in the Emergency Room and require non-emergency care.

E. Contractor shall ensure that a plan or contracting Physician is available 24 hours a day to authorize Medically Necessary post-stabilization care and coordinate the transfer of stabilized Members in an emergency department, if necessary.

4. Changes in Location of PACE Center

Contractor shall provide notification to DHCS at least 180 calendar days prior to making any substantial change in the location of PACE Center. In the event of an emergency or other unforeseeable circumstances, Contractor shall provide notice of the emergency or other unforeseeable circumstance to DHCS as soon as possible.

5. Nondiscrimination and Language Access

A. Contractor shall ensure compliance with Section 1557 of the Affordable Care Act of 2010 and any implementing regulations (42 U.S. Code § 18116; 45 C.F.R. Section 92) that prohibit any entity operating a health program or activity, any part of which receives federal financial assistance, from discriminating against persons based on sex, race, color, national

origin, age or disability. Contractor shall comply with All Plan Letter (APL) 17-011, Standards for Determining Threshold Languages and Requirements for Section 1557 of the Affordable Care Act (June 30, 2017), including any superseding All Plan Letter. Contractor shall use an up-to-date template Notice of Non-Discrimination to be provided by DHCS and shall ensure that its Notice of Non-Discrimination contains contact information for the DHCS Office of Civil Rights and instructions for filing a discrimination complaint directly with the DHCS Office of Civil Rights.

B. Contractor shall ensure compliance with Title VI of the Civil Rights Act of 1964 and any implementing regulations (42 U.S.C. 2000d, 45 C.F.R. section 80) Contractor shall ensure equal access to health care services for limited English proficient Medi-Cal Members or potential members through provision of high quality interpreter and linguistic services.

C. Contractor shall ensure compliance with California nondiscrimination laws, including Section 14029.91 of the Welfare and Institutions Code and Section 11135 of the Government Code.

6. Cultural and Linguistics Program

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

A. Linguistic Capability of Employees

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

B. Group Needs Assessment

1) Contractor shall ensure that a group needs assessment of Members is completed. This group needs assessment shall be conducted in conjunction with the health education group needs assessment, and shall include identification of linguistic needs of the groups that speak a primary language other than English and of all cultural groups within the Service Area.

2) The findings of the assessment shall be maintained as a program description entitled "Cultural and Linguistic Services Program". In the program description, Contractor shall summarize the methodology and findings of the group needs assessment of the linguistic needs of non-English speaking groups, as well as the cultural needs of all plan Members, and outline the proposed services to be implemented to address the timeline for implementation with milestones, and the responsible individual. Contractor shall also identify the individual with overall responsibility for the activities to be conducted under the plan.

3) The results of the group needs assessment shall be considered in the development of any Marketing materials prepared by Contractor.

C. Program Implementation and Evaluation

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

7. Linguistic Services

A. Contractor shall ensure that all monolingual, non-English-speaking, or limited English proficient (LEP) Medi-Cal beneficiaries and potential Members receive 24-hour oral interpreter services at all key points of contact, as defined in paragraph D. of this provision, either through interpreters, telephone language services, or any electronic options Contractor chooses to utilize. Contractor shall ensure that lack of interpreter services does not impede or delay timely access to care.

B. Contractor shall comply with 42 CFR 438.10(d)(4) and provide, at a minimum, the following linguistic services at no cost to Medi-Cal Members or potential members:

1) Oral Interpreters, signers, or bilingual providers and provider staff at all key points of contact. These services shall be provided in all languages spoken by Medi-Cal beneficiaries and not limited to those who speak the threshold or concentration- standards languages.

2) Fully translated written informational materials, including but not limited to the Member Services Guide, 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 who 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.

3) Referrals to culturally and linguistically appropriate community service programs.

4) Auxiliary Aids and Services such as California Relay, Telephone Typewriters (TTY)/Telecommunication Devices for the Deaf (TDD) and American Sign Language.

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

1) A population group of Medi-Cal beneficiaries residing in the Service Area who indicate their primary language as other than English, and who meet a numeric threshold of 3,000 or five percent (5%) of the Medi-Cal population, whichever is lower.

2) A population group of 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 continuous zip codes.

D. Key points of contact include:

1) medical care settings: telephone, advice, and urgent care transactions, and outpatient encounters with health care providers including pharmacists; and

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

8. Participant Advisory Committee

Contractor shall establish a participant advisory committee in accordance with 42 CFR, Section 460.62. Contractor shall ensure that the committee responsibilities

include advisement on educational and operational issues affecting groups who may or may not speak a primary language other than English and cultural competency.

9. Out-of-Network Providers

If Contractor's network is unable to provide necessary services covered under the Contract to a particular Member, Contractor must adequately and timely cover these services out of network for the Member, for as long as the entity is unable to provide them. Out-of-network providers must coordinate with the entity with respect to payment.

Exhibit A, Attachment 10
Scope of Services

1. Covered Services

A. Contractor shall provide or arrange for all Medically Necessary Covered Services for Members. Covered services are those services set for the in California Code of Regulations, title 22, chapter 3, article 4, beginning with section 51301, and title 17, division 1, chapter 4, subchapter 13, beginning with Section 6840, unless otherwise specifically excluded under the terms of this Contract

B. Medi-Cal benefit limitations and conditions relating to amount, duration, scope of services, deductibles, copayments, coinsurance, or other cost-sharing do not apply.

C. Contractor may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. Contractor may place appropriate limits on a service on the basis of criteria such as medical necessity; or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose.

2. Medically Necessary Services

Contractor shall provide or arrange for all Medically Necessary Covered Services for Members as stated in Exhibit E, Attachment 1, provision 26A. Contractor shall ensure that the Medical Necessity of Covered Services is determined through utilization control procedures established in accordance with Exhibit A, Attachment 5, provisions 1 and 3, unless specific utilization control requirements are included as terms of the Contract under sections applicable to specific services. However, no utilization control procedure or any other policy or procedure used by Contractor shall limit services Contractor is required to provide under this Contract.

For purposes of this Contract, the term “Medically Necessary” will include all Covered Services 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. (Cal. Code Regs., title 22, 51303, sub. (a).

3. Initial Health Assessments

Contractor shall conduct an initial comprehensive assessment by the IDT on each Member, periodic reassessments, and unscheduled reassessments as required by 42 CFR, 460.104. This assessment shall include a complete history

and physical examination, and a health education behavioral assessment. The IDT must promptly develop a comprehensive plan of care for each member, implement the plan of care, and evaluate the plan of care in compliance with 42 CFR 460.106.

4. Services for Members

A. Contractor shall ensure that the performance of the initial complete history and physical exam for Members includes, but is not limited to:

1) blood pressure: persons who are normotensive shall have blood pressure measurements at least annually;

2) height and weight;

3) cholesterol: total cholesterol shall be measured at least once every five years;

4) clinical breast examination: Women shall have annual clinical breast examinations;

5) mammogram: all women shall have a screening mammogram every one to two years, concluding at age 75 unless pathology has been demonstrated;

6) pap smear: pap smears shall be performed every one to three years, depending on the presence or absence of risk factors. Regular screening may be discontinued after age 65 in those members who have had regular screening with consistently normal results; and

7) tuberculosis (TB) screening: all Members shall receive testing upon enrollment and annual screenings shall be performed as a part of the history and physical including a Monteux skin test on all persons determined to be high risk.

B. Member Preventive Services

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

1) Contractor shall implement and maintain The Guide to Clinical Preventive Services, a report of the U.S. Preventive Service Task

Force (USPSTF) as the minimum acceptable standard for Member Preventive Health Services. The preceding are a core set of preventive services that shall be provided to all asymptomatic, healthy Members, age 21 and older. (This is not an inclusive list of all appropriate preventive services. The presence of risk factors in individual patients shall affect the type and quantity of preventive services that may be appropriate. A given patient may need additional services or core services at more frequent intervals).

2) Contractor shall provide managed health and other diagnostic and treatment services utilizing the IDT approach to assess and evaluate Member needs, initiate and coordinate required care and otherwise provide effective Case Management for each Member. Contractor shall accept responsibility for management of all health care costs and services for each Member, except for those services which are specifically excluded as stated Exhibit E, Attachment 1, provision 26B.

C. Immunizations

1) Contractor is responsible for assuring that all Members are fully immunized. Contractor shall cover and ensure the timely provision of vaccines in accordance with the most current California Adult Immunization recommendations.

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

3) Appropriate documentation shall be entered in the Member's Medical Record that indicates all attempts to provide immunization(s), instructions as to how to obtain necessary immunizations, or proof of prior immunizations or proof of voluntary refusal of vaccines in the form of a signed statement by the Member. If the responsible party refuses to sign this statement, the refusal shall be noted in the Member's Medical Record.

5. Services for All Members

A. Health Education

Exhibit A, Attachment 10
Scope of Services

1) Contractor shall implement and maintain a health education system that includes programs, services, functions, and resources necessary to provide health education, health promotion and patient education for all Members.

2) Contractor shall maintain administrative oversight of the health education system through a combination of services equivalent to the services of a qualified full-time health educator.

3) Contractor shall provide health education programs and services at no charge to Members directly and/or through Subcontracts or other formal agreements with providers that have expertise in delivering health education services to the Member population

4) Contractor shall ensure the organized delivery of health education programs using educational strategies and methods that are appropriate for Members and effective in achieving behavioral change for improved health.

5) Contractor shall ensure that health education materials are written at the sixth grade reading level and are culturally and linguistically appropriate for the intended audience.

6) Contractor shall maintain a health education system that provides education interventions addressing the following health categories and topics:

    a. risk-reduction and healthy lifestyles; tobacco use and cessation; alcohol and drug use; injury prevention; prevention of sexually transmitted diseases; HIV; nutrition, weight control, and physical activity; and

    b. self-care and management of health conditions: asthma; diabetes; and hypertension.

7) Contractor shall develop, implement, and maintain standards, policies and procedures, and ensure provision of the following:

    a. Member orientation, education regarding health promotion, personal health behavior, and patient education and counseling;

b. Provider education on health education services; and

c. Individual health education behavioral assessment, referral, and follow-up.

8) Contractor shall maintain health education policies and procedures, and standards and guidelines, conduct appropriate levels of program evaluation, and monitor performance by IDT members providing health education services to ensure effectiveness.

9) Contractor shall periodically review the health education system to ensure appropriate allocation of health education resources, and maintain documentation that demonstrates effective implementation of the health education requirements.

10) Contractor shall ensure that individual age appropriate health education behavioral assessments are conducted on all Members within 60 calendar days of Enrollment to identify high-risk behaviors of individual plan Members, to assist providers in prioritizing individual health education needs of their assigned patients related to lifestyle, behavior, environment, and cultural linguistic background and to assist providers in initiating and documenting focused health education interventions, referrals and follow-up. Contractor may modify the tool to fit its population.

11) Contractor shall cover and ensure provision of Comprehensive Case Management including coordination of care services as described in Exhibit A, Attachment 11.

B. Nursing Facility Services

1) Contractor shall ensure that Members, other than Members requesting hospice services, in need of nursing facility services are placed in Facilities providing the appropriate level of care commensurate with the Member's medical needs. These facilities include Skilled Nursing Facilities and Intermediate Care Facilities.

2) Contractor shall base decisions on the appropriate level of care on the determination of whether the Member can live in a community setting without jeopardizing his or her health or safety and not inconsistent with the definitions set forth in California Code of Regulations title 22, sections 51118, 51120, 51120.5, 51121, and

51124.5, and the criteria for admission set forth in title, sections 51335 and 51334.

3) Contractor shall reimburse contracted providers at rates that are not less than Medi-Cal Fee-For Services (FFS) rates, as published and revised by DHCS, including retroactive payment of any additional rate increment based on DHCS retroactive rate adjustments, for equivalent services for the date(s) of service.

C. Vision Care: Lenses

Contractor shall ensure a vision care services system, consistent with good professional practice, which provides that a Member may be seen initially by any of the following:

1) An optometrist or an ophthalmologist.

2) A PCP before referral to an optometrist or an ophthalmologist.

D. Mental Health Services

1) Contractor shall implement and maintain a mental health services system consistent with good professional practice, which provides that a Member may be seen initially by either of the following:

a. Psychiatrist or psychologist, or a psychiatric social worker who is working under qualified supervision; or

b. A PCP before referral to a mental health service provider.

2) Contractor shall implement and maintain policies and procedures for mental health services to include inpatient and outpatient services as determined Medically Necessary by the PCP.

E. Tuberculosis (TB)

1) TB screening, diagnosis, treatment and follow-up are covered under this Contract. Contractor shall provide TB care and treatment in compliance with the guidelines recommended by American Thoracic Society and the Centers for Disease Control and Prevention.

2) Contractor shall coordinate with LHDs in the provision of direct

observed therapy as required in Exhibit A, Attachment 11, provision 16 and Attachment 12.

F. Pharmaceutical Services and Provision of Prescribed Drugs

1) Contractor shall provide pharmaceutical services and prescribed drugs, either directly or through Subcontracts, in accordance with all laws and regulations regarding the provision of pharmaceutical services and prescription drugs to Medi-Cal beneficiaries, including, but not limited to, Title 22, CCR, Section 53214, W&I Code, Section 14185, Title 42, CFR, Sections 460.90, 460.92, 460.3 and 460.84. PACE plans are not subject to the requirements of the California Executive Order N-01-19, transitioning all pharmacy services for Medi-Cal managed care to a fee-for-service benefit, unless as directive making PACE plans subject to Executive Order N-01-19 is issued. If such a directive is issued, then PACE plans must comply with the terms of that directive, the Executive Order, and any implementing authorities.

2) As a minimum, such pharmaceutical services and drugs shall be available to Members during PACE Center business hours.

3) Contractor shall provide a response to a Prior Authorization request from a Contracting provider for a Member's prescription drugs within 24 hours or one business day.

4) Contractor ,also shall allow a Member to continue use of a single source drug which was part of a prescribed therapy in effect immediately prior to the Member's enrollment even if the drug is not covered by Contractor, until the drug is no longer prescribed by the Contracting provider.

5) When the course of treatment provided to a Member by a Contracted provider under emergency circumstances requires the use of drugs, at least a 72-hour supply of a covered outpatient drug or a sufficient quantity of such drugs shall be provided to the Member to last until the Member can reasonably be expected to have a prescription filled.

6) Contractor shall develop and implement effective drug utilization reviews and treatment outcomes to optimize the quality of pharmacy services.

7) Contractor's process should also ensure that drug utilization reviews are appropriately conducted and that pharmacy service and drug utilization Encounter Data are provided to DHCS on a monthly basis.

6. Transportation

Transportation services must be provided in compliance with 42 CFR 460.76.

7. Dietary Services

Dietary services are covered as set forth in 42 CFR 460.78

Exhibit A, Attachment 11
Case Management and Coordination of Care

1. Interdisciplinary Team Case Management

A. Contractor shall provide managed health and other diagnostic and treatment services utilizing the IDT approach to comprehensively assess and evaluate Member needs, initiate and coordinate required care, and otherwise provide effective Case Management for each Member in compliance with 42 CFR 460.102, 460.104, 460.106, 460.114, 460.92, and 460.98.

B. Contractor shall accept responsibility for management of all health care costs and services for each Member, except for those services which are specifically excluded as stated in Exhibit E, Attachment 1, provision 26B.

2. Nursing Facility Level of Care

Contractor's IDT shall be responsible for assessing Members for meeting skilled or intermediate nursing facility level of care criteria in accordance with California Code of Regulations, title 22, Sections 51334 and 51335. Evaluation and determination of Members prior to Enrollment in Contractor's plan shall be determined solely by DHCS as meeting the level of care requirements.

3. Infection Control

A. Contractor shall implement and maintain an effective plan for the surveillance, prevention, and control of infection in compliance with 42 CFR 460.74. Contractor shall ensure that this plan shall include the scope (both patient care and support services), the persons responsible, the policies and procedures and frequency of review (at least every 2 years), the role and responsibilities of each service, the monitoring activities, and approval by the governing body.

B. Contractor shall implement and maintain policies for prevention and control of infection transmission in patients and personnel which include:

1) the application of universal precaution procedures;

2) the availability of adequate infection control devices and supplies in the patient areas;

3) infectious or bio-hazardous waste disposal procedures complying with applicable state and federal regulations;

4) isolation precautions and procedures;

5) cleaning and sterilization methods, agents, and schedules, including maintenance of autoclave, spore testing, storage of sterile packs, etc.; and

6) training and continuing education of all personnel.

C. Contractor shall implement and maintain a procedure for reporting infectious diseases to public health authorities as required by state law.

D. Contractor shall ensure that its infection control policies are maintained by its Subcontractors.

E. Contractor shall ensure the review of patient infections that present the potential for prevention or intervention to reduce the risk of future occurrence.

4. Inpatient Care

Contractor shall implement and maintain procedures to monitor Quality of Care provided in an inpatient setting to its Members. If Contractor delegates the QI functions to hospitals, Contractor shall maintain procedures to monitor the delegated function, including review of services provided by its Physicians within the hospital.

5. 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 in order to ensure coordinated service delivery and efficient and effective joint case management.

6. Dental

Contractor shall ensure a dental care services system, consistent with good professional practice that guarantees Members direct access to dental care as determined by the IDT.

Exhibit A, Attachment 11
Case Management and Coordination of Care

7. Immunization Registry Reporting

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

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

ED drugs and other ED therapies are excluded from coverage under Medi-Cal unless such drug is used to treat a condition other than sexual or erectile dysfunction, and as approved by the Food and Drug Administration. ED drugs and other ED therapies are covered under this contract if they are determined necessary by the interdisciplinary team to improve and maintain the participant's overall health status, as provided under 42 CFR section 460.92(c).

Exhibit A, Attachment 12
Local Health Department Coordination

1. Subcontracts

If the Contractor makes referrals to LHDs for public health services listed in paragraphs A through D below, Contractor shall negotiate in good faith and execute a Subcontract with the LHD in each county that is covered by this Contract in each county zip code service area that is covered by this Contract. The Subcontract shall specify: the scope and responsibilities of both parties in the provision of services to Members; billing and reimbursements; reporting responsibilities; and how services are to be coordinated between the LHD and the Contractor, including exchange of medical information as necessary. The Subcontract shall meet the requirements contained in Exhibit A, Attachment 6, provision 13, regarding Subcontracts.

A. STD services for the disease episode, as specified in Exhibit A, Attachment 8, Provision 10, by DHCS, for each STD, including diagnosis and treatment of the following STDs: syphilis, gonorrhea, chlamydia, herpes simplex, chancroid, trichomoniasis, human papilloma virus, non-gonococcal urethritis, lymphogranuloma venereum and granuloma inguinale.

B. HIV Testing and Counseling as specified in Exhibit A, Attachment 8, provision 11.

C. Immunizations as specified in Exhibit A, Attachment 8, provision 12.

D. To the extent that Contractor does not meet this requirement on or before four months after the effective date of this Contract, Contractor shall submit documentation substantiating reasonable efforts to enter into Subcontracts.

2. Local Mental Health Plan Coordination

A. If the Contractor makes referrals to Medi-Cal local mental health plans for specialty mental health services, Contractor shall negotiate in good faith and execute a Subcontract with the MHP in each county zip code service area that is covered by this Contract. The Subcontract shall specify: the scope and responsibilities of both parties in the provision of services to Members; billing and reimbursements; reporting responsibilities; and how services are to be coordinated between the MHP and the Contractor, including exchange of medical information as necessary. The Subcontract shall meet the requirements contained in Exhibit A, Attachment 6, provision 13, regarding Subcontracts. The subcontract shall address:

Exhibit A, Attachment 12
Local Health Department Coordination

1) protocols and procedures for referrals between Contractor and the MHP;

2) protocols for the delivery of Specialty Mental Health Services, including the MHP's provision of clinical consultation to Contractor for Members being treated by Contractor for mental illness;

3) protocols for the delivery of mental health services within the PACE IDT scope of practice;

4) protocols and procedures for the exchange of medical records information, including procedures for maintaining the confidentiality of medical records.

5) Procedures for the delivery of Medically Necessary Covered Services to Members who require Specialty Mental Health Services, including:

    a) Pharmaceutical services and prescription drugs;

    b) Laboratory, radiological and radioisotope services;

    c) Emergency room facility charges and professional services;

    d) Emergency and non-emergency medical transportation;

    e) Home health services; and

    f) Medically Necessary Covered Services to Members who are patients in psychiatric inpatient hospitals.

6) Procedures for transfers between inpatient psychiatric services and inpatient medical services to address changes in a Member's medical or mental health condition; and

7) Procedures to resolve disputes between Contractor and the MHP.

Exhibit A, Attachment 13
Member Services

1. Members Rights and Responsibilities

A. Member Rights and Responsibilities

Contractor shall develop, implement, and maintain a formal Participant Bill of Rights approved by CMS, in compliance with 42 U.S.C. 1395eee(b)(2)(B), 42 CFR 460.32(a)(5), 460.110, and 460.112, which includes written policies that address the Member's rights and responsibilities and shall communicate these to its employees, Members, providers, and, upon request, potential members.

Contractor assures that the rights and protections of the Participant Bill of Rights will be provided, as required by 42 CFR 460.32(a)(5).

Contractor shall have established documented procedures to respond to and rectify a violation of a participant's rights, as required by 42 CFR 460.118.

Contractor must have written policies and implement procedures to ensure that the participant, his or her representative, if any, and staff understand these rights, as required by 42 CFR 460.116.

1) Contractor's written Participant Bill of Rights shall include the following:

   a. to be treated with respect, giving due consideration to the Member's right to privacy and the need to maintain confidentiality of the Member's medical information.

   b. not to be discriminated against in the delivery of required services based on race, ethnicity, national origin, religion, sex, age, mental or physical disability or source of payment.

   c. the Member has the right to be fully informed of his (her) functional status and to request a reassessment by the IDT, to be given reasonable advance notice, in writing, of any transfer to another treatment setting and the justification for the transfer (e.g. due to medical reasons or for the Member's welfare or that of other Members).

   d. to be provided with information about the organization and its services;

e. to be able to choose a PCP if another PCP is employed by Contractor;

f. to participate in decision making regarding their own health care, including the right to refuse treatment;

g. to voice grievances, either verbally or in writing, about the organization or the care received;

h. to receive oral interpretation services for their language;

i. To formulate advance directives;

j. to have access to sexually transmitted disease services and emergency services outside the Contractor's network pursuant to the federal law;

k. to request a State Medi-Cal Hearing, including information on the circumstances under which an expedited Hearing is possible;

l. to have access to, and where legally appropriate, receive copies of, amend, or correct their Medical Record;

m. to disenroll upon request;

n. to receive written Member informing materials in alternative formats, including Braille, large size print, and audio format upon request and in accordance with Welfare and Institutions Code section 14182, subdivision (b), criteria (12);

o. to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;

p. to receive information about available treatment options and alternatives, presented in a manner appropriate to the Member’s condition and ability to understand;

q. to receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR 164.524 and 164.526 (2014); and

r. freedom to exercise these rights without adversely affecting how they are treated by the Contractor, providers, or the State

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

B. Members' Right to Confidentiality

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

1) Contractor shall ensure that Facilities implement and maintain procedures that guard against disclosure of Confidential Information to unauthorized persons inside and outside the network.

2) Contractor shall counsel Members on their right to confidentiality and Contractor shall obtain Member's consent prior to release of Confidential Information, unless such consent is not required pursuant to California Code of Regulations, title 22, section 51009.

C. Contractor must limit use of restraints as provided in 42 CFR 460.114, as follows:

1) the PACE organization must limit use of restraints to the least restrictive and most effective method available. The term restraint includes either a physical restraint or a chemical restraint.

a. a physical restraint is any manual method or physical or mechanical device, materials, or equipment attached or adjacent to the participant's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body.

b. a chemical restraint is a medication used to control behavior or to restrict the participant's freedom of movement and is not a standard treatment for the participant's medical or psychiatric condition.

2) If the interdisciplinary team determines that a restraint is needed to ensure the participant's physical safety or the safety of others, the use must meet the following conditions:

a. be imposed for a defined, limited period of time, based upon the assessed needs of the participant.

b. be imposed in accordance with safe and appropriate restraining techniques.

c. be imposed only when other less restrictive measures have been found to be ineffective to protect the participant or others from harm.

d. be removed or ended at the earliest possible time.

3) The condition of the restrained participant must be continually assessed, monitored, and reevaluated.

D. Members' Rights to Advance Directives

Contractor shall implement and maintain written policies and procedures respecting advance directives in accordance with the requirements of 42 CFR, 422.128.

2. PACE Staff

A. Contractor shall maintain the capability to provide Member services to Medi-Cal Members or potential members through sufficient assigned and knowledgeable staff.

B. Contractor shall ensure PACE staff are trained on all contractually required Member or potential member service functions including policies, procedures, and scope of benefits of this Contract. Contractor shall provide training to maintain and improve the skills and knowledge of each staff member with respect to the individual's specific duties that results in his or her continued ability to demonstrate the skills necessary for the performance of the position, as required by 42 CFR 460.66.

C. Contractor shall develop a training program for each personal care attendant to establish the individual's competency in furnishing personal care services and specialized skills associated with specific care needs of individual members.

D. Contractor shall ensure that PACE 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 and referral to appropriate clinical services staff.

E. Each member of Contractor's staff that has direct member contact, (employee or contractor) must meet the following conditions, as required by 42 CFR 460.64:

1) Be legally authorized (for example, currently licensed, registered or certified if applicable) to practice in the State in which he or she performs the function or action;

2) Only act within the scope of his or her authority to practice;

3) Have 1 year of experience with a frail or elderly population. If the individual has less than 1 year experience but meets all other requirements in this Provision 2.E, then the individual must receive appropriate training from the PACE organization on working with a frail or elderly population upon hiring;

4) Meet a standardized set of competencies for the specific position description established by the PACE organization and approved by CMS before working independently.

5) Be medically cleared for communicable diseases and have all immunizations up-to-date before engaging in direct member contact.

F. Federally-defined qualifications for physician. In addition to the qualification specified in paragraph (D) of this section, a physician must meet the qualifications and conditions in 42 CFR 410.20.

3. Written Member Information

A. Contractor shall provide to all Members, upon Enrollment in Contractor’s plan, the Member Enrollment Agreement/Terms and Conditions and Disclosure Form materials, which constitute a fair disclosure of the provisions of the covered health care services. In the event there are changes in the Member Enrollment Agreement/Terms and Conditions at anytime during the Member’s enrollment, Contractor must provide to the

Exhibit A, Attachment 13
Member Services

Member an updated copy of the information at least 60 days before any change, and explain the changes to the Member and his or her representative or caregiver in a manner they understand.

B. To provide Member information in any format other than as printed materials, including but not limited to in electronic format or upon request, Contractor must submit their process to DHCS for review and approval before implementing.

C. Contractor shall ensure that all written Member information is provided to Members at a sixth grade reading level, or as determined appropriate through the Contractor's group needs assessment and approved by DHCS. The written Member information shall ensure Members' understanding of the health plan processes and ensure the Member's ability to make informed health decisions.

D. Member information shall include the Member Enrollment Agreement/Terms and Conditions and Disclosure Form materials, significant mailings and notices, and any notices related to Grievances, actions, and Appeals. All Member information shall be in a format that is easily understood and in a font size no smaller than 12-point.

1) Written Member-information shall be translated into the identified threshold and concentration languages discussed in Exhibit A, Attachment 9, provision 10.

2) Written Member information shall be provided in alternative formats (including Braille, large size print, or audio format) and through auxiliary aids and services upon request and in a timely fashion appropriate for the format being requested, and taking into consideration the special needs of Members with disabilities or LEP.

3) Contractor shall establish policies and procedures to enable Members to make a standing request to receive all Member information in a specified threshold language or alternative format.

4) Member information in English shall include taglines and information on how to request auxiliary aids and services, including materials in alternative formats, in large print font and all State threshold languages, as identified by DHCS. The taglines shall explain the availability of written Member information translated in that language or oral interpretation to understand the information

provided, and the toll-free and TTY/TDD telephone number for these language assistance services.

E. Contractor shall provide to all Members a Member Enrollment Agreement/Terms and Conditions upon Enrollment that includes the following information:

1) The plan name, address, toll-free telephone number and service area covered by the PACE plan.

2) A description of all covered benefits and all available services provided by Contractor, including health education, interpretive services provided by plan personnel and at the PACE center and an explanation of any service exclusions from coverage or charges for services.

3) An explanation of the eligibility criteria and intake process for Enrollment in Contractor's health plan.

4) Procedures for accessing Covered Services including that Covered Services shall be obtained through the plan's providers unless otherwise allowed under this contract:

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

5) Procedures for requesting a change in PCP, if more than one PCP is employed by Contractor, including requirements for a change in PCP, and reasons for which a request may be denied.

6) The purpose and value of scheduling an IHA appointment.

7) A description of the IDT and responsibilities.

8) Explanation of the Member reassessment process by the health plan and for Member requests for reassessment.

9) The appropriate use of health care services.

10) 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 Member's right to interpretive services, at no cost, to assist in receiving after hours services.

11) Definition of what constitutes an emergency medical condition, emergency health care and post-stabilization services, in accordance with 42 CFR § 460.100, and that prior authorization is not required to receive emergency services. Include the use of 911 for obtaining emergency services.

12) Procedure for obtaining emergency health care from specified plan providers or from non-plan providers, including outside Contractor's Service Area.

13) Process for referral to specialists in sufficient detail so Member can understand how the process works, including timeframes.

14) Procedures for obtaining any transportation services offered by Contractor, and how to obtain such services.

15) Procedures for filing a grievance or appeal pursuant to 42 CFR 460.122, either orally or in writing, or over the phone, including procedures for appealing decisions regarding Member's coverage, benefits or relationship to the organization or other dissatisfaction with the Contractor and/or providers. Include the toll-free telephone number a Member can use to file a grievance or appeal, and the title, address, and telephone number of the person responsible for processing and resolving grievances and providing assistance in completing the request. Information regarding the process shall include the requirements for timeframes to file a grievance or appeal, and the timelines for the Contractor to acknowledge receipt of grievances, to resolve 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 grievance is being resolved.

16) The causes for which a Member shall lose entitlement to receive services under this Contract as stipulated in Exhibit A, Attachment 16, provision 3.

17) Procedures for Disenrollment, including an explanation of the Member's right to Disenroll without cause at any time.

Exhibit A, Attachment 13
Member Services

18) An explanation of specific rights to which a Member is entitled.

19) A description of the Member's premiums and procedures for payment of premiums, including share of cost.

20) Explanation of a Member's obligation to inform Contractor of a move or more than a 30-day absence from Contractor's Service Area.

21) Information on the Member's right to the Medi-Cal State Hearing process, the method for obtaining a Hearing, the timeframe to request a Hearing, and the rules that govern representation in a Hearing. Include information on the circumstances under which an expedited State Hearing is possible and information regarding assistance in completing the request, regardless grievance has been submitted or if the grievance has been resolved, pursuant to California Code of Regulations, title 22, Section 53452, when a health care service requested by the Member or provider has been denied, deferred, or modified. Information on State Hearings shall also include information on the timelines which govern a Member's right to a State Hearing, pursuant to Welfare and Institutions Code Section 10951 and the State Department of Social Services' Public Inquiry and Response Unit toll- free telephone number (1-800 952-5253) to request a State Hearing. Information shall include that services previously authorized by the Contractor will continue while the State Hearing is being resolved if the Member requests a Hearing in the specified timeframe.

22) Procedures for providing female Members with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the Member's designated source of primary care if that source is not a woman's health specialist.

23) Information on the availability of transitional Medi-Cal eligibility and how the Member may apply for this program. Contractor shall include this information with all Member Service Guides sent to Members after the date such information is furnished to Contractor by DHCS.

24) Information on how to access State resources for investigation and resolution of Member complaints, including description of the DHCS

Medi-Cal Managed Care Ombudsman Program and toll-free telephone number (1-888-452-8609).

25) A notice regarding the positive benefits of organ donations and how a Member can become an organ or tissue donor. Pursuant to California Health and Safety Code, section 7158.2, this notice must be provided upon enrollment and annually thereafter in the evidence of coverage, (Member Enrollment Agreement/Terms and Conditions), health plan newsletter, or any other direct communications with Members.

26) A statement as to whether the Contractor uses provider financial bonuses or other incentives with its contracting providers of health care services and that the Member may request additional information about these bonuses or incentives from the plan, the Member's provider or the provider's group or independent practice association, pursuant to California Health and Safety Code, section 1367.10.

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

28) Policies and procedures regarding a Members' right to formulate advance directives. This information shall include the Member's right to be informed by the Contractor of state law regarding advance directives, and to receive information from the Contractor regarding any changes to that law. The information shall reflect changes in State law regarding advance directives as soon as possible, but no later than 90 calendar days after the effective date of change.

29) Instructions on how a Member can view online, or request a copy of, Contractor's non-proprietary clinical and administrative policies and procedures; and

30) Any other information determined by DHCS to be essential for the proper receipt of Covered Services.

F. Contractor shall provide the following information to the Member or Member's family unit either in the form of a cover letter or insert in the above prescribed Member Enrollment Agreement/Terms and Conditions:

1) each Member's effective date of Enrollment and term of Enrollment; and

2) the name, telephone number, and PACE Center address of the PCP chosen by or assigned to the Member.

G. Member Identification Card

Contractor shall issue a Member 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 by the IDT.

4. Notification of Changes in Access to Covered Services

A. Contractor shall ensure Medi-Cal Members are notified in writing of any changes in the availability or location of Covered at least 30 calendar days prior to the effective date of such changes. In the event of an emergency or other unforeseeable circumstance, Contractor shall provide notice of the emergency or unforeseeable circumstance to DHCS as soon as possible. The notification must also be presented to and approved in writing by the Department prior to its release.

5. Primary Care Physician Selection

A. Contractor shall implement and maintain DHCS' approved policy and procedures to ensure that each Member has an appropriate and available PCP upon Enrollment in Contractor's plan.

B. Contractor shall ensure that the Member is assigned to a PCP who is an employee of Contractor's plan or otherwise approved by DHCS and CMS

and is responsible for the medical coordination of the Member's health care consistent with federal and State statutes and regulations. In the event the Member becomes dissatisfied with the PCP, Contractor shall allow the Member to choose another PCP who is employed by Contractor. Contractor shall employ sufficient number of PCPs at all its PACE Centers to ensure access to appropriate high-quality health care.

C. Contractor shall provide the Member sufficient information (verbal and written) in the appropriate language and reading level about the PCPs available.

Exhibit A, Attachment 14
Member Grievance and Appeals

1. Member Grievance Procedure

A. Contractor shall establish and maintain a written procedure for submitting, documenting, processing, and resolving all medical and nonmedical Member Grievances, as required by 42 CFR 460.32(a)(6) and 460.120 in the timeframes outlined in provision 4, paragraph C, of this Attachment while maintaining confidentiality of the Member's Grievance. Contractor shall submit the procedure to DHCS for review and approval prior to implementation.

B. Contractor shall designate an officer of the plan (e.g., chief executive officer, administrative director, or medical director) to have primary responsibility for maintenance of the procedures, review of their operations, and utilization of any emergent patterns of Grievances to formulate policy changes and procedural improvements in the administration of the plan.

C. A grievance is a complaint, either written or oral, expressing dissatisfaction with service delivery or the quality of care furnished.

1) Process to resolve grievances. A PACE organization must have a formal written process to evaluate and resolve medical and nonmedical grievances by members, their family members, or representatives.

2) Notification to members. Upon enrollment, and at least annually thereafter, the PACE organization must give a member written information on the grievance process.

3) Minimum requirements. At a minimum, the PACE organization's grievance process must include written procedures for the following:

a. How a member files a grievance.

b. Documentation of a member's grievance.

c. Response to, and resolution of, grievances in a timely manner.

d. Maintenance of confidentiality of a member's grievance.

4) Continuing care during grievance process. The PACE organization must continue to furnish all required services to the member during the grievance process.

5) Explaining the grievance process. The PACE organization must discuss with and provide to the member in writing the specific steps, including timeframes for response, that will be taken to resolve the member's grievance.

6) Analyzing grievance information. The PACE organization must maintain, aggregate, and analyze information on grievance proceedings. This information must be used in the PACE organization's internal quality assessment and performance improvement program.

D. A written summary of Grievances including number, type, location, and disposition shall be reviewed periodically by the governing body of the plan and by an officer of the plan or designee. As a part of this review, the reviewers evaluating the summary will determine an emergent pattern of Grievances to be utilized in the formation of policy changes and procedural components in the plan's administration. The execution of each review shall be documented.

E. Contractor shall provide a system for addressing any cultural or linguistic requirements related to the processing of Member Grievances prescribed in the contract between the plan and the department.

2. Grievance Systems Oversight

A. Contractor shall maintain in its files copies of all Grievances, the responses to them, and logs recording them; for a period of five years from the date the Grievance was filed.

B. Contractor shall submit a summary of all Grievances in Contractor’s quarterly report. The Grievance summary is due 45 days from the date of the end of the reporting quarter.

C. Contractor shall ensure a procedure for the expedited review and disposition of Grievances in the event of a serious or imminent health threat to a Member, in accordance with Health and Safety Code section 1368.01.

Exhibit A, Attachment 14
Member Grievance and Appeals

3. Member Grievance Assistance

A. Contractor shall provide at least one telephone number for the filing of complaints that shall ensure that Members calling from within the plan's Service Area will not have to pay long distance charges. Contractor shall provide written notice to Members of the telephone numbers and procedures for filing Grievances.

B. A person at the PACE Center shall promptly furnish Grievance forms and a copy of the Grievance procedures to Members when requested in person, by telephone, or by mail.

C. A person at the PACE Center shall provide assistance in the filing of Grievances.

4. Member Grievance Process

A. Each Grievance received in person or by telephone or in writing in accordance with the established procedure shall be recorded in writing, including the date, time, identification of the Member filing the Grievance, identification of the individual recording the Grievance, description of the Grievance, action taken by the health plan, identification of the individual responsible for resolving Grievances, disposition, and date of notification to the Member. Contractor shall submit all medical quality of care Grievances immediately to the medical director or Chief Medical Officer for action.

B. The management or supervisory staff responsible for the services or operations which are the subject of the Grievance shall promptly review the Grievance.

C. Within five days of receipt of a Grievance, Contractor shall provide to the Member who files a Grievance an acknowledgement of receipt of the Grievance and identification of the person or unit, which may be contacted about the Grievance. Contractor shall notify the Member of the disposition of the Grievance or document reasonable efforts to resolve the Grievance normally within 30 days of the date the Grievance was received. When Contractor is unable to distinguish between Grievances and inquiries, they shall be processed as Grievances.

D. Any Member whose Grievance is resolved or unresolved shall have the right to request a State Hearing. Submission of a Grievance shall not be construed as a waiver of the member's right to request a State Hearing in

accordance with California Code of Regulations, title 22, sections 50951, 51014.1, and 51014.2.

E. In the event resolution is not reached within 30 days, the Member shall be notified in writing by Contractor of the status of the Grievance and shall be provided with an estimated completion date of the resolution. Such notice shall include a statement notifying the Member they may exercise their right to request a State Hearing in accordance with California Code of Regulations, title 22, sections 50951, 51014.1, and 51014.2.

F. Contractor shall ensure that Members shall continue to receive care during the Grievance process.

G. Contractor shall ensure that there is no discrimination against a Member solely on the grounds that the Member filed a Grievance.

5. Discrimination Grievances

A. Contractor must designate a Section 1557/Civil Rights coordinator responsible for ensuring compliance with non-discrimination requirements and investigating grievances related to non-compliance with federal and state non-discrimination law. This includes language access complaints and complaints alleging failure to make reasonable accommodations under the ADA. Contractor must also adopt a process to ensure the prompt and equitable resolution of these discrimination-related grievances. Contractor shall submit the process to DHCS for review and approval prior to implementation.

B. Contractor's Section 1557/Civil Rights coordinator must be available to:

1) Answer questions and provide appropriate assistance to Contractor staff, Members and Applicants regarding Contractor's state and federal non-discrimination legal obligations;

2) Advise Contractor about non-discrimination best practices and accommodating persons with disabilities; and

3) Investigate and process discrimination grievances, including those alleging violations of the ADA, Section 504, Section 1557, and/or Government Code Section 11135.

C. Contractor shall use a template Notice of Non-Discrimination provided by DHCS to meet the obligation to post its discrimination grievance

information as required by Section 1557 of the Affordable Care Act and its implementing regulations (45 CFR 92.8); Sections 14029.91 and 14029.92 of the Welfare and Institutions Code; and All Plan Letter (APL) 17-011, Standards for Determining Threshold Languages and Requirements for Section 1557 of the Affordable Care Act (June 30, 2017), including any superseding All Plan Letter.

D. Within ten calendar days of mailing a discrimination grievance resolution letter to a Member or Eligible Beneficiary, Contractor must forward to the DHCS Office of Civil Rights (OCR) the following information regarding the discrimination grievance:

1. the original complaint;

2. the provider's or other accused party's response to the grievance;

3. contact information for the personnel responsible for the Contractor's response to the grievance;

4. contact information for the Member or Eligible Beneficiary and for the provider or other accused party that is the subject of the grievance;

5. all correspondence with the Member or Eligible Beneficiary regarding the grievance, including the grievance acknowledgment and grievance resolution letter(s) sent to the Member or Eligible Beneficiary; and

6. any other information that is relevant to the allegation of discrimination;

E. A Member, Eligible Beneficiary, or other interested person may file a discrimination grievance directly with DHCS OCR at any time. Submission of a discrimination grievance to Contractor shall not be construed as a waiver of complainant's other rights regarding the allegedly discriminatory conduct, including the right to submit a grievance alleging discrimination in the Medi-Cal program directly to DHCS OCR or, as applicable, the United States Department of Health and Human Services Office for Civil Rights.

Exhibit A, Attachment 14
Member Grievance and Appeals

6. Member Appeals Process

A. Contractor shall establish and maintain a procedure for submitting, documenting, processing, resolving, and evaluating all Member Appeals in accordance with federal PACE regulations 42 CFR, Sections 460.104(d)(2), 460.122, and 460.124, 460.32(a)(6), and 460.154(n).

B. In accordance with federal PACE regulation 42 CFR, Section 460.124, any Member whose Appeal is resolved or unresolved shall have the right to request a State Hearing. Submission of a Grievance and or an Appeal shall not be construed as a waiver of the Member's right to request a State Hearing in accordance with California Code of Regulations title 22, sections 50951, 51014.1, 51014.2, and 53261.

7. Member Notification of Denial, Deferral or Modification of Requests for Prior Authorization, and Appeal

A. Contractor shall notify Members of denial, deferral, or modification of request for Prior Authorization, in accordance with Title 42 CFR 460.104 and 460.122.

B. If a member (or his or her designated representative) believes that the member needs to initiate, eliminate, or continue a particular service, the appropriate members of the interdisciplinary team, as identified by the interdisciplinary team, must conduct a reassessment. The interdisciplinary team member(s) may conduct the reassessment via remote technology when the interdisciplinary team determines that the use of remote technology is appropriate and the service request will likely be deemed necessary to improve or maintain the participant's overall health status and the participant or his or her designated representative agrees to the use of remote technology.

An in-person reassessment must be conducted when participant or his or her designated representative declines the use of remote technology.

C. The PACE organization must have explicit procedures for timely resolution of requests by a member or his or her designated representative to initiate, eliminate, or continue a particular service.

D. Except as provided in paragraph in E of this section, the interdisciplinary team must notify the member or designated representative of its decision to approve or deny the request from the member or designated representative as expeditiously as the member's condition requires, but no

later than 72 hours after the date the interdisciplinary team receives the request for reassessment.

E. The interdisciplinary team may extend the 72–hour timeframe for notifying the member or designated representative of its decision to approve or deny the request by no more than 5 additional days for either of the following reasons:

1) The member or designated representative requests the extension.

2) The team documents its need for additional information and how the delay is in the interest of the member.

F. The PACE organization must explain any denial of a request to the member or the member's designated representative orally and in writing. The PACE organization must provide the specific reasons for the denial in understandable language. The PACE organization is responsible for the following:

1) Informing the member or designated representative of his or her right to appeal the decision as specified in § 460.122.

2) Describing both the standard and expedited appeals processes, including the right to, and conditions for, obtaining expedited consideration of an appeal of a denial of services as specified in § 460.122.

3) Describing the right to, and conditions for, continuation of appealed services through the period of an appeal as specified in § 460.122(e).

4) If the interdisciplinary team fails to provide the member with timely notice of the resolution of the request or does not furnish the services required by the revised plan of care, this failure constitutes an adverse decision, and the member's request must be automatically processed by the PACE organization as an appeal in accordance with § 460.122.

Exhibit A, Attachment 15
Marketing

1. Marketing

Contractor shall comply with the requirements of 42 CFR 460.82 regarding marketing:

A. Information that a PACE organization must include in its marketing materials.

1) A PACE organization must inform the public about its program and give prospective members the following written information:

a. An adequate description of the PACE organization's Enrollment and Disenrollment policies and requirements.

b. PACE enrollment procedures.

c. Description of benefits and services.

d. Premiums.

e. Other information necessary for prospective members to make an informed decision about enrollment.

2) Marketing information must be free of material inaccuracies, misleading information, or misrepresentations.

B. Approval of marketing information.

1) CMS must approve all marketing information before distribution by the PACE organization, including any revised or updated material.

2) CMS reviews initial marketing information as part of an entity's application for approval as a PACE organization, and approval of the application includes approval of marketing information.

3) Once a PACE organization is under a PACE program agreement, any revisions to existing marketing information and new information are subject to the following:

a. Time period for approval. CMS approves or disapproves marketing information within 45 days after CMS receives the information from the organization.

Exhibit A, Attachment 15
Marketing

b. Deemed approval. Marketing information is deemed approved, and the organization can distribute it, if CMS and the State administering agency do not disapprove the marketing material within the 45–day review period.

C. Special language requirements

A PACE Organization must furnish printed marketing materials to prospective and current members as specified below:

1) In English and in any other principal languages of the community, as determined by the State in which the PACE organization is located. In the absence of a State standard, a principal language of the community is any language that is spoken in the home by at least 5 percent of the individuals in the PACE organization's service area.

2) In Braille, if necessary.

D. Information on restriction of services.

1) Marketing materials must inform a potential member that he or she must receive all needed health care, including primary care and specialist physician services (other than emergency services), from the PACE organization or from an entity authorized by the PACE organization.

2) All marketing materials must state clearly that PACE members may be fully and personally liable for the costs of unauthorized or out-of–PACE program agreement services.

E. Prohibited marketing practices.

A PACE organization must ensure that its employees or its agents do not use prohibited marketing practices including but not limited to those prohibited Marketing practices listed in 42 CFR 460.82(e) and the following:

1) Discrimination of any kind, except that marketing may be directed to individuals eligible for PACE by reason of their age.

2) Activities that could mislead or confuse potential members, or misrepresent the PACE organization, CMS, or the State administering agency.

3) Gifts or payments to induce enrollment, unless the gifts are of nominal value as defined in CMS guidance, are offered to all potential enrollees without regard to whether they enroll in the PACE program, and are not in the form of cash or other monetary rebates.

4) Marketing by any individual or entity that is directly or indirectly compensated by the PACE organization based on activities or outcomes unless the individual or entity has been appropriately trained on PACE program requirements.

   a. PACE organizations are responsible for the activities of contracted individuals or entities who market on their behalf.

   b. PACE organizations that choose to use contracted individuals or entities for marketing purposes must develop a method to document training has been provided.

5) Unsolicited door-to-door marketing or other unsolicited means of direct contact, including calling or emailing a potential or current participant without the individual initiating the contact.

2. Training and Approval of Marketing Representatives

Contractor shall develop an orientation and training program for Marketing Representatives and Marketing supervisors to ensure that all staff performing Marketing activities or distributing Marketing material are appropriately trained, have passed the DHCS' Medi-Cal Marketing exam and are approved by DHCS to conduct Marketing activities.

A. Contractor is responsible for all Marketing activities conducted on behalf of Contractor. Contractor shall be held liable for any and all violations by any Marketing Representative. Contractor shall ensure, in addition to compliance with the requirements of California Code of Regulations, 22, sections 53400 through 53458 that:

   1) All Marketing Representatives, including supervisors, have satisfactorily completed Contractor's Marketing orientation and training program and the DHCS Marketing Representative

Examination prior to engaging in Marketing activities on behalf of Contractor;

2) Marketing Representative shall not provide Marketing services on behalf of more than one Contractor; and

3) Marketing Representatives do not engage in Marketing practices that discriminate against an eligible beneficiary because of race, creed, age, color, sex, religion, national origin, ancestry, marital status, sexual orientation, physical or mental handicap, or health status.

B. Training Program

1) Contractor shall develop a training and orientation program that shall train staff and prepare Marketing Representatives for the DHCS' Medi-Cal Marketing examination and to perform Marketing activities for Contractor. Contractor shall develop a staff orientation and Marketing Representative's orientation/training manual.

2) Contractor shall provide a memorandum of understanding (in the format provided by DHCS) that all Marketing Representatives must complete prior to taking the DHCS' Medi-Cal Marketing examination.

3) Contractor shall provide certification by Contractor that the Marketing Representatives have completed the orientation and training program

C. Marketing Presentations

Contractor shall ensure that all Marketing presentations made to eligible Members contain adequate information about Contractor to allow Members to exercise informed judgment in choosing to enroll in Contractor's plan. All Marketing presentations shall fully disclose the availability of and restrictions upon the services provided by Contractor. The information and procedures shall conform to California Code of Regulations, title 22, section 53404, and as a minimum, specify:

1) Scope, access to, and availability of services;

2) An explanation of the requirements of confidentiality of any information obtained from Medi-Cal beneficiaries;

3) An explanation of the nature of the Membership identification which shall authorize the Member to obtain services;

4) An explanation that Members shall obtain all covered health care services required and rendered in non-emergency situations, through the plan's providers;

5) An explanation that medical services required in an emergency may be obtained at all times from specified plan providers or from non-plan providers, if necessary;

6) An explanation that Enrollment is voluntary;

7) An explanation that Enrollment is subject to a verification or processing period of 15 to 45 days; and

8) An explanation that Disenrollment is possible under the conditions specified in Title 22 CCR Section 53440 and only after action by DHCS.

3. DHCS Approval

A. Contractor shall not conduct Marketing activities without written approval of its Marketing plan from DHCS.

B. All Marketing materials, and changes in Marketing materials, including but not limited to, all printed materials, illustrated materials, videotaped, website, and media scripts, shall be approved in writing by DHCS prior to distribution.

C. Contractor's orientation and training program and changes in the orientation and training program shall be approved in writing by DHCS prior to implementation.

4. Signed Certifications

A. Contractor shall provide a signed certification that Contractor shall abide by all Medi-Cal Marketing requirements and conditions.

B. Contractor shall provide a signed certification that all Marketing staff are employees of the Contractor.

Exhibit A, Attachment 15
Marketing

5. Medi-Cal Marketing Representative Reporting Requirements

Contractor shall submit to DHCS a status of Marketing Representatives every three months.

6. Mass Marketing Mailers

Contractor may request mass market mailings of their Marketing material to Medi-Cal beneficiaries by using the mailing services provided by DHCS. Contractor shall notify DHCS 45 days in advance of the mailer being sent. Contractor shall be invoiced and all departmental costs associated to the mass mailing services shall be reimbursed to DHCS within 30 days of receipt of invoice.

Exhibit A, Attachment 16
Enrollments and Disenrollments

1. Contractor shall comply with the Member Enrollment and Disenrollment requirements set forth in 42 CFR 460.150 through 460.172.

2. Submittal of Enrollment and Disenrollment Files

Contractor shall submit Enrollments and Disenrollments in accordance with PACE Policy Letter 20-01 and updates thereto.

3. Enrollment

Contractor shall accept as Members Medi-Cal beneficiaries voluntary aid categories as defined in Exhibit E, Attachment 1, Definitions, provision 35.

A. General

Eligible Medi-Cal beneficiaries residing within the approved service area of Contractor, as defined in Exhibit E, Attachment I, provision 92, may voluntarily apply for Enrollment under this Contract at any time during the term of this Contract. Beneficiaries meeting the eligibility requirements of 42 CFR 460.150 shall be accepted by Contractor in the order in which they apply and without regard to health status or mental condition disability, age, gender, race, religion, creed, color, national origin, marital status, sexual orientation, or ancestry.

Eligibility to enroll in a PACE program is governed by 42 CFR 460.150, which states:

1) General rule. To enroll in a PACE program, an individual must meet eligibility requirements specified in this section. To continue to be eligible for PACE, an individual must meet the annual recertification requirements specified in Section 460.160.

2) Basic eligibility requirements. To be eligible to enroll in PACE, an individual must meet the following requirements:

   a. be 55 years of age or older;

   b. be determined by the State administering agency to need the level of care required under the State Medicaid plan for coverage of nursing facility services, which indicates that the Individual's health status is comparable to the health status of individuals who have participated in the PACE demonstration waiver programs;

c. reside in the service area of the PACE organization; and

d. meet any additional program specific eligibility conditions imposed under the PACE program agreement. These additional conditions may not modify the requirements of paragraph (b)(1) through (b)(3) of this section.

3) Other eligibility requirements.

a. At the time of enrollment, an individual must be able to live in a community setting without jeopardizing his or her health or safety

b. The criteria used to determine if an individual's health or safety would be jeopardized by living in a community setting must specified in the program agreement.

i) Eligibility under Medicare and Medicaid. Eligibility to enroll in a PACE program is not restricted to an individual who is either a Medicare beneficiary or Medicaid beneficiary. A potential PACE enrollee may be, but is not required to be, any or all of the following:

(1) entitled to Medicare Part A;

(2) enrolled under Medicare Part B; and/or

(3) eligible for Medicaid.

To be eligible for payment under this Contract, the individual must be eligible for Medi-Cal.

The enrollment process to be followed by Contractor is set forth in 42 CFR 460.152. The enrollment agreement must comply with the requirements of 42 CFR 460.154. Other enrollment procedures set forth in 42 CFR 460.156.

B. Coverage

1) A member's enrollment in Contractor's PACE plan is effective on the first day of the calendar month following the date Contractor receives the signed enrollment agreement, as provided by 42 CFR

460.158. The member's continuation of enrollment is governed by the requirements of 42 CFR 160. The term of enrollment shall continue indefinitely unless this Contract expires, is terminated or the Member is disenrolled under the conditions described in provision 3.

2) Enrollment is contingent continued financial eligibility for Medi-Cal, and initial eligibility for long-term care as determined by DHCS.

3) The member's eligibility for long-term care must be reevaluated by DHCS at least annually, unless DHCS determines there is no reasonable expectation of improvement or significant change in an individual's condition during the period because of the severity of chronic condition, or degree of impairment of functional capacity of the member. A member may be deemed to continue to be eligible for the PACE program notwithstanding a determination that the individual no longer nursing facility level of care if, in accordance with regulations, in the absence of continued coverage under a PACE program the individual reasonably would be expected to meet such requirement within the succeeding 6-month period. (42 USC 1395eee(c)(3) and (4).) As provided by 42 CFR 460.160:

   a. DHCS may permanently waive the annual recertification requirement for a member if it determines that there is no reasonable expectation of improvement or significant change in the member's condition because of the severity of a chronic condition or the degree of impairment of functional capacity.

   b. Contractor must retain in the member's medical record the documentation of the reason for waiving the annual recertification requirement.

   c. If DHCS determines that a PACE member no longer meets the Medi-Cal nursing facility level of care requirements, the member may be deemed to continue to be eligible for the PACE program until the next annual reevaluation, if, in the absence of continued coverage under this program, the member reasonably would be expected to meet the nursing facility level of care requirement within the next 6 months.

      DHCS has establish criteria to use in making the determination of "deemed continued eligibility." DHCS, in

consultation with Contractor, makes a determination of deemed continued eligibility based on a review of the member's medical record and plan of care. These criteria must be applied in reviewing the member's medical record and plan of care. In accordance with PACE Policy Letter 02-14 and updates thereto.

C. Information to Prospective Members

Contractors must inform each Medi-Cal Member signing an Enrollment Agreement, in writing, of the following:

1) Member enrollment will be effective on the first day of the month following Contractor submission of the Enrollment Agreement to DHCS.

2) At any time, a member may request to disenroll from the PACE Organization, without having to provide a reason for the request. The disenrollment will be effective the first day of the month following the date the PACE Organization receives the request.

4. Disenrollment

As required by 42 CFR 460.172, Contractor must have a procedure in place to document the reasons for all voluntary and involuntary disenrollments. Contractor must make that documentation available for review by CMS and DHCS. Contractor must use the information on voluntary disenrollments in the PACE organization's internal quality improvement program.

A. Voluntary Disenrollment

1) A member’s voluntary disenrollment is effective on the first day of the month following the date the PACE organization receives the member’s notice of voluntary disenrollment.

2) A PACE member may voluntarily disenroll from the program without cause at any time.

3) The Contractor must ensure that its employees or contractors do not engage in any practice that would reasonably be expected to have the effect of steering or encouraging disenrollment of participants due to a change in health status.

Exhibit A, Attachment 16
Enrollments and Disenrollments

B. Involuntary Disenrollment

A member's involuntary disenrollment occurs after the Contractor meets the requirements set forth in this section and is effective on the first day of the next month that begins 30 days after the day the PACE organization sends notice of the disenrollment to the member.

As provided in 42 CFR 460.164, Contractor may involuntarily disenroll a member for any of the following reasons:

1) The member, after a 30-day grace period, fails to pay or make satisfactory arrangements to pay any premium due to the Contractor;

2) The member, after a 30-day grace period, fails to pay or make satisfactory arrangements to pay any applicable Medi-Cal spenddown liability or any amount due under the post-eligibility treatment of income process, as permitted under §§460.182 and 460.184;

3) The member, or the member's caregiver engages in disruptive or threatening behavior, and exhibits either of the following:

   a. A member whose behavior jeopardizes his or her health or safety, or the safety of other; or

   b. A member with decision-making capacity who consistently refuses to comply with his or her individual plan of care or the terms of the PACE enrollment agreement.

   c. A member's caregiver who engages in disruptive or threatening behavior exhibits behavior that jeopardizes the member's health or safety, or the safety of the caregiver or others.

   The Conractor may not disenroll a member on the grounds that the participant has engaged in noncompliant behavior if the behavior is related to a mental or physical condition of the participant, unless the participant's behavior jeopardizes his or her health or safety, or the safety of others. Noncompliant behavior includes repeated noncompliance with medical advice and repeated failure to keep appointments.

4) The member moves out of the PACE program service area or is out of the service area for more than 30 consecutive days, unless the Contractor agrees to a longer absence due to extenuating circumstances;

5) The member is determined to no longer meet the State Medicaid nursing facility level of care requirements and is not deemed eligible;

6) The Contractor's agreement with CMS and DHCS is not renewed or is terminated; and

7) The Contractor is unable to offer health care services due to the loss of State licenses or contracts with outside providers.

As required by 42 CFR 460.166, in disenrolling a member, Contractor must use the most expedient process allowed as set forth in this Contract, coordinate the disenrollment date between Medicare and Medicaid (for a member who is eligible for both Medicare and Medicaid), and give reasonable advance notice to the member. Until the date enrollment is terminated, members must continue to use PACE organization. Contractor must continue to furnish all needed services until the date of disenrollment.

Contractor shall establish a formal procedure for Contractor-initiated involuntary Disenrollments that meets the approval of 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 20 days to respond to the proposed action.

C Contractor must submit a written request for Disenrollment and the documentation supporting the request to DHCS for approval. The supporting documentation must establish the reason for proposing to involuntary disenroll the member and all efforts to remedy the situation. DHCS shall review the request and render a decision in writing within ten State working days of receipt of a Contractor request and necessary documentation. If Contractor-initiated request for Disenrollment is approved by DHCS, DHCS shall process the Disenrollment. Contractor shall be notified by DHCS of the decision, and if the request is granted, shall be notified of the effective date of the Disenrollment. Contractor shall notify the Member of the Disenrollment for cause (involuntary disenrollment) if DHCS grants Contractor-initiated request for Disenrollment.

Exhibit A, Attachment 16
Enrollments and Disenrollments

D. Membership shall cease no later than midnight on the last day of the first calendar month after Contactor'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 shall return to DHCS any Capitation payment forwarded to Contractor for persons not enrolled under this Contract.

E. In the case of an individual whose enrollment ceases for any reason (including that the individual no longer qualifies as a PACE program eligible individual, the termination of a PACE program agreement, or otherwise), Contractor shall provide assistance to the individual in obtaining necessary transitional care through appropriate referrals and making the individual's medical records available to new providers, and take action in compliance 42 CFR 460.168 to facilitate the individual's reinstatement in other Medicare and Medicaid programs. Contractor may reinstate a previously enrolled member.

Exhibit A, Attachment 17
Reporting Requirements

1. Contractor shall furnish the following reports and information to the DHCS and/or ISCD (unless specifically exempted from reporting by DHCS):

   A. On an annual basis:

      1) The financial audit report in compliance with this Exhibit A, Attachment 2, provision 2. This report shall be submitted to the DHCS no later than 180 calendar days after the close of Contractor's fiscal year;

      2) A disclosure statement in compliance with this Exhibit A, Attachment 1, provision 2A;

      3) Facility aggregate report for PACE Centers and Contracted Providers;

      4) Enrollment Agreement: Terms and Conditions update;

      5) Results of Member satisfaction surveys;

      6) Contractor shall submit an updated Contracted Provider Directory, which, at a minimum, contains the following information:

         a. headers to indicate city or region names (in alphabetical order);

         b. specialty (e.g. Optometry);

         c. provider's name (last, first-listed alphabetically);
            Street address
            City including zip codes
            Telephone number including area code

         d. languages (other than English) spoken at the provider site; and

         e. medical Group/Institutional/Specialty name (e.g. University of California)

      7) Summary of all Quality Assurance activities;

      8) Progress report of major events, program applications and developments, research activities and administration. The report

shall include, but not be limited to, Member demographic characteristics; medical diagnosis by disease categories, and physical, cognitive, and functional status; member/program census, service cost and utilization statistics, difficulties or special problems, pertinent facts, or interim findings. Submit copy of progress report to CMS if different from above;

9) Financial reports relevant to affiliates as specified in California Code of Regulations, title 22, section 53330;

10) Copies of any financial reports submitted to other public or private organizations as specified in California Code of Regulations title 22, section 53324 ,subdivision (d);

11) Additions and deletions to Marketing Representative staff;

12) Summary of Member Grievances, Appeals, and Unusual Incidents;

13) Summary of Provider Grievances; and

14) Listing of all Contractor's Subcontract providers which includes a listing of new Subcontractors and those contracts terminated during the quarter.

B. On a quarterly basis (within forty-five calendar days of the end of each quarter under this Contract):

1) Utilization and statistical data in compliance with California Code of Regulations title 22, section 53314 in accordance with the reporting format approved by DHCS.

2) Financial reports required by California Code of Regulations title 22, section 53324 subdivision (c), unless waived in writing by the Department.

2. Other reports to be submitted to the DHCS include:

A. information requested by the DHCS to conduct medical, financial, Contract monitoring, and review activities in accordance with Welfare and Institutions Code, sections 14456 and 14457;

B. results of Quality of Care studies and/or progress reports shall be submitted every six months;

Exhibit A, Attachment 17
Reporting Requirements

C. new and revised Contractor's policies and procedures upon the request of DHCS;

D. notification of possible Third-Party Tort Liability situations, including Workers' Compensation situations. This information shall be submitted within ten calendar days of discovery;

E. names of Contractor's employees who are subject to the requirements of California Code of Regulations title 22 CCR section 53600, subdivision (f). This information shall be reported to the Department within ten days of the employment date;

F. information necessary for evaluation of compliance with California Code of Regulations title 22, section 53402;

G. a completed disclosure statement at the time the Contract is executed, annually with Contractor's Certified Public Accountant audit and financial statement, and within thirty-five days of a written request by DHCS or DHHS of any change in previously submitted information;

H. contractor shall notify DHCS within ten days of any changes in key personnel pursuant to PACE Policy Letter 06-03;

I. contractor shall notify DHCS of Disenrollments that have occurred after MEDS/FAME processing cut-off date for hard copy submissions due to deaths and/or out of Service Area; and

J. contractor shall submit to DHCS a monthly report listing all active Members as of the first day of the month including pertinent Medi-Cal, Medically Needy Only/Share of Cost and Medicare eligibility information for each Member. The reports shall also include a listing of all new (additions) and terminating (deletions) Member activity for the month, and the reason for any listed terminations.

K. Submittal of Inpatient Days Information

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

requested, for the administration of the disproportionate share hospital program.

Exhibit B
Budget Detail and Payment Provisions

Budget Detail and Payment Provisions

1. Invoicing and Payment
2. Budget Contingency Clause
3. Prompt Payment Clause
4. Amounts Payable
5. Contractor Risk in Providing Services
6. Capitation Rates
7. Capitation Rates Constitute Payment in full
8. Determination of Rates
9. Redetermination of Rates-Obligation Changes
10. Reinsurance
11. Catastrophic Coverage Limitation
12. Financial Performance Guarantee
13. Recovery of Capitation Payments
14. Requirements for Payments of Retroactive Capitation (Retrocapitation) for Eligible Members

Exhibit B
Budget Detail and Payment Provisions

1. Invoicing and Payment

A. For services satisfactorily rendered, and upon receipt and approval of the invoices, DHCS agrees to compensate the Contractor for actual expenditures incurred in accordance with the rates and/or allowable costs specified herein.

2. Budget Contingency Clause

A. It is mutually agreed that if the Budget Act of the current year and/or any subsequent years covered under this 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.

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

3. Prompt Payment Clause

Payment will be made in accordance with, and within the time specified in, Government Code Chapter 4.5, commencing with Section 927.

4. Amounts Payable

Any requirement of performance by the State and Contractor for the period of the Contract will be dependent upon the availability of future appropriations by the Legislature for the purpose of the Medi-Cal program.

5. Contractor Risk In Providing Services

Contractor shall 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 Contractor after having fulfilled obligations under this Contract shall be retained by Contractor.

6. Capitation Rates

Exhibit B
Budget Detail and Payment Provisions

A. The State shall remit to Contractor a Capitation payment for each month for each Medi-Cal Member that appears on the approved list of Members supplied to Contractor by DHCS. The capitation rate shall be the amount specified in Exhibit B, Attachment 1, Rate of Medi-Cal Reimbursement. The payment period for health care services shall commence on the first day of operations, as determined by DHCS. Capitation payments shall be made in accordance with the schedule of capitation payment rate at the end of each month. For aid codes see DEFINITION, Eligible Beneficiary.

B. For Share of Cost Members, payment shall be made at the end of the month following certification by Contractor that the Member's Share of Cost has been collected and cleared through the DHCS' Point of Service device prior to the first calendar date listed on DHCS' Managed Care Plan FAME Cut-Off/Processing Schedule.

C. 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 Contractor, then the split aid code shall 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 codes splits, and the rates of payment for such new aid codes, in writing to Contractor as soon as practicable after such aid code splits occur.

D. Capitation payments shall be made in accordance with the schedule of Capitation Rates set forth in Exhibit B, Attachment 1, Rate of Medi-Cal Reimbursement.

7. Capitation Rates Constitute Payment In Full

Capitation rates for each rate period, as calculated by DHCS, are prospective rates and constitute payment in full, subject to any stop loss reinsurance provisions, on behalf a Member for all Covered Services required by such Member and for all Administrative Costs incurred by the Contractor in providing or arranging for such services. DHCS is not responsible for making payments for recoupment of losses.

8. Determination Of Rates

A. DHCS shall determine the capitation rates on a yearly basis. DHCS shall make an annual redetermination of rates for each rate year defined as the 12-month period from January 1 through December 31. DHCS shall

attempt to negotiate rates in good faith for each rate year in accordance with Title 42, CFR, Section 460.182. DHCS reserves the right to establish rates on an actuarial basis for each rate year which it shall do in accordance with Welfare and Institutions Code Section 14301.1(n), and Title 42, CFR, Sections 438.6 and 460.182. All payments and rate adjustments are subject to appropriations of funds by the Legislature and the Department of Finance approval. Further, all payments are subject to the availability of Federal congressional appropriation of funds.

B. 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 an amendment to this contract in accordance with the provisions of Exhibit E, Attachment 2, Provision 3. Amendment Process. Change orders shall be utilized in the event that DHCS and the Contractor cannot reach an agreement. Negotiations may still continue and the Contractor may initiate a dispute in accordance with Exhibit E, Attachment 2, Provision 18, Disputes and retains the right to terminate the contract is unable to reach agreement with DHCS. A change order to this Contract shall be in accordance with W&I Code Section 14301(c) and the provision of Exhibit E, Attachment 2, provision 4, Change Requirements, subject to the following:

1) The amendment or change order shall be effective as of January 1 of each year covered by this Contract.

2) In the event there is any delay in a determination to increase or decrease capitation rates, so that an amendment or change order may not be processed in time to permit payment of new rates commencing January 1, the payment to Contractor shall continue at the rates stated in an R Letter sent to the Contractor by DHCS. The R Letter shall serve as notification from DHCS to Contractor of the capitated rates, and the time period for which these rates will be applied. The R Letter shall not be considered exempt from any requirement of this Contract. Those continued payments shall constitute interim payment only. Upon final approval of the amendment or change order providing for the rate change, DHCS shall make retroactive adjustments for those months for which interim payment was made.

3) By accepting payment of new annual rates prior to full approval by all control agencies of the amendment or change order 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:

a. Any underpayment by the State shall be paid to Contractor within 30 calendar days after final approval of the new rates.

b. Any overpayment to Contractor shall be recaptured by the State's withholding the amount due from Contractor's next capitation check. If the amount to be withheld from that capitation check exceeds 25 percent of the capitation payment for that month, amounts up to 25 percent shall be withheld from successive capitation payments until the overpayment is fully recovered by the State.

4) If mutual agreement between DHCS and the Contractor cannot be attained on Capitation rates for subsequent rate years Contractor shall retain the right to terminate the Contract. Notification of intent to terminate a Contract shall be in writing and provided to DHCS at least nine months prior to the effective date of termination, subject to any earlier termination date negotiated in accordance with Exhibit E, Attachment 2, provision 14. DHCS shall pay the Capitation rates last offered for that rate period until the Contract is terminated.

5) DHCS shall make every effort to notify and consult with Contractor regarding proposed redetermination of rates pursuant to this section or provision 7 below at the earliest possible time prior to implementation of the new rate.

9. 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 percent of cost (California Code of Regulations title 22 Section 53869) to the Contractor. Any adjustments shall be effectuated through an amendment to this Contract subject to the following provisions:

A. The amendment shall be effective as of the first day of the month in which the change in obligations is effective, as determined by DHCS; and

Exhibit B
Budget Detail and Payment Provisions

B. In the event DHCS is unable to process the 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 amendment providing for the change in obligations, DHCS shall make adjustments for those months for which interim payment was made.

C. DHCS and Contractor may negotiate an earlier termination date, pursuant to Exhibit E, Attachment 2, provision 14, 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.

10. 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 California Code of Regulation title 22, section 53252 (a)(2)(A) &(B), Reinsurance shall not limit Contractor's liability below $5,000 per Member for any 12-month period as specified by DHCS, and Contractor may obtain Reinsurance for the total cost of services provided to Members by non-Contractor emergency service providers and for 90 percent of all costs exceeding 115 percent of its income during any Contractor fiscal year.

11. Catastrophic Coverage Limitation

DHCS may limit 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 shall 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.

12. 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 90 calendar days following termination or expiration of this Contract unless DHCS has a financial claim against Contractor. Further rights and obligations of the Contractor and DHCS, in regards to the Financial Performance Guarantee, shall be as specified in California Code of Regulations title 22 section 53865.

13. Recovery Of Capitation Payments

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

A. If DHCS determines that a Member has either been improperly enrolled, due to ineligibility of the Member to enroll in Contractor's plan, residence outside of Contractor's Service Area or pursuant to California Code of Regulations title 22, section 53440(a)(2) or should have been disenrolled with an effective date in a prior month. DHCS may recover the Capitation payments made to Contractor for the Member for the months in question**.** To the extent permitted by law, Contractor may seek to recover any payments made to providers for Covered Services rendered for the month(s) in question. Contractor shall inform providers that claims for services provided to Members during the month(s) in question may be paid by the DHCS fiscal intermediary, if the Member is determined eligible for the Medi-Cal program.

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 pursuant to Exhibit A, Attachment 11, Provision 18. Excluded Services Requiring Member Disenrollment, or under other circumstances as approved by DHCS. If Contractor retains the capitation payments, Contractor shall provide or arrange and pay for all Medically Necessary Covered Services for the Member, until the Member is disenrolled on a nonretroactive basis pursuant to Exhibit A, Attachment 16, provision 3.

B. As a result of Contractor's failure to perform their contractual responsibilities to comply with mandatory federal Medicaid requirements, the 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 payment made to Contractor. If recovery of the full amount at one time imposes a financial hardship on Contractor, DHCS, at its discretion may grant a Contractor's request to repay the recoverable amounts in monthly installments over a period of consecutive months not to exceed six months.

C. DHCS determines that any other erroneous or improper payment not mentioned above has been made to Contractor. DHCS may recover the amounts determined by an offset to the Capitation payment made to Contractor. If recovery of the full amount at one time imposes a financial hardship on Contractor, DHCS, at its discretion, may grant a Contractor's request to repay the recoverable amounts in monthly installments over a period of consecutive months not to exceed six months. At least 30 days prior to seeking any such recovery, DHCS shall notify Contractor to explain the improper or erroneous nature of the payment and to describe the recovery process.

14. Requirements for Payments of Retroactive Capitation (Retrocapitation) for Eligible Members

A. Contractor may submit to DHCS a request for payment of retroactive Capitation payments for Members that continued to receive all services offered by the PACE plan, but for whom Capitation payments were not made by DHCS due to the Member's eligibility being placed on hold status. Requests for retrocapitation payments shall be made immediately upon clearance of the Member's eligibility status or no later than 30 days after the Member's eligibility status has been restored. Retrocapitation payments are subject to the discretion of the Department, and will be made only if all of the following conditions have been met:

1) Contractor's request for payment of retrocapitation must provide adequate and sufficient verifiable documentation for each request, including all information requested by DHCS;

2) Enrollment in the PACE plan has been verified through MEDS for each month retrocapitation payments are being requested;

3) During the period for which Contractor is requesting a retrocapitation payment, the Contractor has continued to satisfactorily demonstrate that the plan reconciles and reports eligibility for all Members on a monthly basis using the FAME report as well as supplemental reports submitted by Medi-Cal Managed Care;

4) The request for retrocapitation payments for members with a previous unmet share of cost has been reconciled and submitted on a monthly basis In accordance with Exhibit B, provision 3,; and

5) Contractor is, in the DHCS' determination, in substantial compliance with all contractual requirements at the time a request for retrocapitation is made.

B. Retrocapitation payment requests shall be made within 30 days from the end of the month during which the Member for whom retrocapitation payments are being requested has had their eligibility status removed from hold status. Under no circumstances will the DHCS consider retrocapitation payment requests more than six months from the time the Member's eligibility status has been restored.

C. All decisions by DHCS with respect to approval or denial of a request for retrocapltatlon shall be final.

D. Documentation required to be submitted by the PACE plan includes, but is not limited to the following:

1) Medi-Cal Eligibility Verification from Point of Service (POS) device and/or Notice of Action issued from the County for the requested month(s) of retrocapitation;

2) HCP FAME Record displaying the Member's eligibility and HCP status, with the months for which retrocapitation is requested highlighted;

3) All Batch Transmittals, Enrollment Form and Agreement submitted to DHCS for processing, including initial enrollment documents and resubmitted documents;

4) Letter from the County in which the Member resides providing verification of county residence and date of residency; and

5) Monthly share of cost listing for the requested month(s) of retrocapitation, with the Member's name and share of cost amount highlighted.

E. For the purpose of processing retrocapitation requests, DHCS shall have available and shall provide to Contractor upon request, a form for

Exhibit B
Budget Detail and Payment Provisions

Contractor to use when submitting to DHCS all required Member information for DHCS to review in support of Contractor's request for retrocapitation.

PACE Plan Name
Contract Number

Exhibit B, Attachment 1
Rate of Medi-Cal Reimbursement

Federal regulation (42 CFR 460.182) requires that the state makes monthly capitation payments to PACE organization for Medi-Cal participants which are less than the amount that would otherwise have been paid (AWOP) under the State plan if those participants were not enrolled in the PACE program.

Effective January 1, 2018, the capitation rates shall be compliant with State Plan Amendment 18-005.

[County] – [Plan Code] – [HCP Number]

Commencing [DATE]		Full Duals	Non-Duals
Groups	Aid Codes	Rate	Rate
Family	01, 02, 0A, 3E, 3L, 3M, 3N, 3U, 3W, M3		
SPD	20, 23, 24, 26, 27, 36, 60, 63, 64, 66, 67, 2E, 2H, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6R, 10, 13, 14, 16, 17, 1E, 1H		
Adult	53, 81		
Adult Expansion	M1, 7U, L1, L6		

Exhibit E
Additional Provisions

1. Additional Incorporated Exhibits

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

A. Exhibit A, Attachment 1 - Organization and Administration of the Plan
B. Exhibit A, Attachment 2 - Financial Information
C. Exhibit A, Attachment 3 - Management Information System
D. Exhibit A, Attachment 4 - Quality Improvement System
E. Exhibit A, Attachment 5 - Utilization Management
F. Exhibit A, Attachment 6 - Provider Network
G. Exhibit A, Attachment 7 - Provider Relations
H. Exhibit A, Attachment 8 - Provider Compensation Arrangements
I. Exhibit A, Attachment 9 - Access and Availability
J. Exhibit A, Attachment 10 - Scope of Services
K. Exhibit A, Attachment 11 - Case Management and Coordination of Care
L. Exhibit A, Attachment 12 – Local Health Department Coordination
M. Exhibit A, Attachment 13 - Member Services
N. Exhibit A, Attachment 14 - Member Grievance and Appeals
O. Exhibit A, Attachment 15 - Marketing
P. Exhibit A, Attachment 16 - Enrollments and Disenrollments
Q. Exhibit A, Attachment 17 - Reporting Requirements

2. Priority of Provisions

In the event of a conflict between the provisions of Exhibit E and any other exhibit of this Contract, excluding Exhibit C, the provisions of Exhibit E shall prevail.

Exhibit E, Attachment 1
Definitions

As used in this Contract, unless otherwise expressly provided or the context otherwise requires, the following definitions of terms shall govern the construction of this Contract:

Action means a termination, suspension, or reduction (which includes denial of a service based on OGC interpretation of 42 CFR 431) of Medicaid eligibility or covered services. It also means determinations by skilled nursing facilities and nursing facilities to transfer or discharge residents and adverse determinations made by a State with regard to the preadmission screening and annual resident review requirements of section 1919(e)(7) of the Act.

Actual Non-Service Expenditures means Contractor's actual amounts incurred for non-service expenditures, including both administrative and care management costs, for Full Benefit Dual Eligible Members and excludes costs incurred by Contractor prior to the start of this Risk Corridor. Any reinsurance costs reflected will be net reinsurance costs.

Actual Service Expenditures means Contractor's actual amount paid for providing services to Full Benefit Dual Eligible Members priced at Contractor fee level, and shall comprise of all provider payments for services to this population, including risk-sharing arrangements or sub-capitation payments.

Adjusted Non-Service Expenditures means Contractor's Actual Non-Service Expenditures, adjusted to reflect the exclusion of costs greater than 125 percent of the non-medical cost per Member per month across all participating Contractors and including any consideration given to Contractor for any significant, non-typical membership mixes that may cause this exclusion to come into effect as well as the exclusion of reinsurance costs which is the net of reinsurance premiums; and adjustments resulting from DHCS' review of Contractor's non-service expenditures to address any inappropriate or excessive non-service expenditures, including executive compensation and stop loss expenditures.

Adjusted Service Expenditures means Contractor's Actual Service Expenditures adjusted to reflect the following reductions from any recoveries of other payers outside of claims adjudication, including those pursuant to coordination of benefits, third party liability, rebates, supplemental payments, adjustments in claims paid, adjustments from providers including adjustments to claims paid, and Member contributions to care; and adjustments resulting from DHCS' review of Contractor reimbursement methodologies and levels to address any excessive pricing.

Administrative Costs means only those costs that arise out of the operation of the plan excluding direct and overhead costs incurred in the furnishing of health care services, which would ordinarily be incurred in the provision of these services whether or not through a plan.

Exhibit E, Attachment 1
Definitions

Adult Day Health Care (ADHC) means an organized day program of therapeutic, social and health activities and services provided to persons 55 years or older or other adults with functional impairments, either physical or mental, for the purpose of restoring or maintaining optimal capacity for self-care as set forth in California Code of Regulations, title 22, Section 78007.

Adult Day Health Care (ADHC) Center means a facility licensed to provide adult day health care, or a distinct portion of a licensed health facility in which such care is provided in a specialized unit, under a special permit issued by the Department of Public Health pursuant to California Code of Regulations, title 22, section 54105.

Advance Directive: a written instruction, such as a living will or durable power of attorney for health care, recognized under state law (whether statutory or as recognized by the courts of the state), relating to the provision of health care when the individual is incapacitated.

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

Allied Health Personnel means specially trained, licensed or credentialed health workers other than Physicians, podiatrists, and Nurses.

Allowed Medical Expenses means Contractor's actual expenses incurred and accounted for in accordance with Generally Accepted Accounting Principles (GAAP) for Covered Services delivered to Members during each period, including expenses incurred for utilization management and quality assurance activities, shared risk pools, incentive payments to providers, and excluding administrative costs as defined in Title 28 CCR Section 1300.78.

A. For the MLR calculation, designated medical expense amounts included in the capitation rates that Contractor is required to pay providers, such as for intergovernmental transfers and Hospital Quality Assurance Fees, are excluded.

B. Global sub-capitation payments made by Contractor, where entire medical expenses are shifted to another entity, possibly net of utilization management or quality assurance, shall not exceed 95 percent, unless otherwise agreed by DHCS of the net capitation payments for consideration within Allowed Medical Expenses.

C. Payments by Contractor to related party providers shall not exceed the rate paid by Contractor for the same services to unrelated parties within the same county. Related parties are defined by GAAP.

Exhibit E, Attachment 1
Definitions

Ambulatory Care means the type of health services that are provided on an outpatient basis.

Appeal means a Member's action taken with respect to the PACE organization's noncoverage of, modification of, or nonpayment for, a service including denials, reductions or termination of services, as defined by federal PACE regulation 42 CFR Section 460.122.

Applicant means any Member, as defined in this Attachment, provision 59, who has applied for Membership in Contractor's plan.

At-Risk Service means any identified Covered Service, as defined in this Attachment, provision 26A which Contractor agrees to accept responsibility to provide or arrange for in exchange for the Capitation payment.

Beneficiary Identification Card (BIC) means a permanent plastic card issued by the State to Medi-Cal recipients of entitlement programs which is used by Contractors to verify Medi-Cal eligibility.

Capitated Revenues means the amount of the PACE Capitation payments/revenues paid to Contractor by DHCS for all services provided to participants under this Contract.

Capitated Service means any Medi-Cal Covered Service for which Contractor receives Capitation payment.

Capitation means the monthly payment to Contractor for Medi-Cal services covered by the Contract.

Capitation Rate means the amount paid per Member per month for services to be provided at-risk.

Case Management means responsibility for referral, consultation, ordering therapy, admission to hospitals, follow-up care, and prepayment approval of referred services. It includes responsibility for location, coordination, and monitoring all medical care on behalf of a Member.

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

Exhibit E, Attachment 1
Definitions

Center means a Facility operated by a PACE Organization where Primary Care is furnished to plan Members.

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

Complete Claim means a claim that can be processed without obtaining additional information from the provider of the service or from a third party.

Cold-Call Marketing means any unsolicited personal contact by the Contractor with a potential Member for the purpose of marketing (as identified within the definition of Marketing).

Confidential Information means specific facts or documents identified as "confidential" by any law, regulations or contractual language.

Contract means this written agreement between DHCS and Contractor.

Contracting Officer means the single administrator of this Contract appointed by the Director DHCS. On behalf of DHCS, the Contracting Officer shall make all determinations and take all action as are appropriate to implement this Contract, subject to the limitations of the Contract.

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

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

Contractor means an entity doing business as [PACE Plan Name].

Corrective Actions means specific identifiable activities or undertakings of Contractor which address program deficiencies or problems identified by formal audits or by CMS or DHCS monitoring or oversight activities.

Cost Avoid means Contractor bills or 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.

Exhibit E, Attachment 1
Definitions

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

Covered Services means those items and services provided by Contractor under the provisions of Welfare and Institutions Code, section 14132 and the California State Plan, except those services specifically excluded under this paragraph, state law, or the California State Plan.

A. Covered Services include, but are not limited to:

1) Acute inpatient care, including the following:

a. Ambulance

b. Emergency room care and treatment room services

c. Semi-private room and board

d. General medical and nursing services

e. Medical surgical/intensive care/coronary care unit

f. Laboratory tests, x-rays and other diagnostic procedures

g. Drugs and biologicals

h. Blood and blood derivatives

i. Surgical care, including the use of anesthesia

j. Use of oxygen

k. Physical, occupational, respiratory therapies, and speech language pathology services

l. Social Services

m. Inpatient Mental Health

2) Interdisciplinary Team Assessment and Treatment Planning

Exhibit E, Attachment 1
Definitions

3) Adult Day Health Center and Clinic Services as set forth in California Code of Regulations, title 22, sections 54309 through 54323 including, but not limited to, the following:

   a. Primary Care, including Physician and nursing services

   b. Social work services

   c. Restorative therapies, including physical therapy and occupational therapy

   d. Personal care and supportive services

   e. Nutritional counseling

   f. Recreational therapy

   g. Meals

   h. Transportation

4) Home Care Services, including Home Health Services

5) Outpatient mental health services

6) Drugs and biologicals

7) Laboratory tests, x-rays, and other diagnostic procedures

8) Medical specialty services including, but not limited to the following:

   a. Anesthesiology

   b. Audiology

   c. Cardiology

   d. Dentistry

   e. Dermatology

   f. Gastroenterology

g. Gynecology

h. Internal medicine

i. Nephrology

j. Neurosurgery

k. Oncology

l. Ophthalmology

m. Oral surgery

n. Orthopedic surgery

o. Otorhinolaryngology

p. Plastic surgery

q. Pharmacy consulting services

r. Podiatry

s. Psychiatry

t. Pulmonary disease

u. Radiology

v. Rheumatology

w. General surgery

x. Thoracic and vascular surgery

y. Urology

9) Nursing Facility care, including the following:

a. Semi-Private room and board

b. Physician and skilled nursing services

c. Custodial care

d. Personal care and assistance

e. Drugs and biologicals

f. Physical, occupational, recreational therapies, and speech language pathology, if necessary

g. Social services

h. Medical supplies and appliances

10) Other services determined necessary by the IDT to improve and maintain the member's overall health status

11) Prosthetics, orthotics, durable medical equipment, corrective vision devices, such as eyeglasses and lenses, hearing aids, dentures, and repair and maintenance of these items

12) Major Organ Transplants

B. Covered Services do not include:

1) Any service that has not been authorized by the IDT, even if it is a required service, unless it is an emergency service;

2) Services rendered in a non-emergency setting or for a non-emergency reason without Prior Authorization;

3) Prescription and over-the-counter drugs not prescribed by Contractor's Physician;

4) In an inpatient Facility, private room and private duty nursing services (unless medically necessary), and nonmedical items for personal convenience such as telephone charges and radio or television rental (unless specifically authorized by the IDT as part of the Member's plan of care);

5) Cosmetic surgery, which does not include surgery that is required for improved functioning or a malformed part of the body resulting from an accidental injury or for reconstruction following a mastectomy;

6) Experimental medical, surgical or other health procedures;

7) Care in a government hospital (VA, federal/state hospital);

8) Any services rendered outside of the United States, except in accordance with 42 CFR, 424.122 and 424.124, or as permitted under the Medi-Cal approved Medicaid Plan;

Credentialing means the recognition of professional or technical competence. The process involved may include registration, certification, licensure and professional association membership.

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 in California) Program.

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

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

Dietitian/Nutritionist means a person who is registered or eligible for registration as a Registered Dietitian by the Commission on Dietetic Registration (Bus. & Prof. Code, chapter 5.65, sections 2585 and 2586).

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

Disenrollment means the Department-approved discontinuance of a Member's entitlement to receive Covered Services under the terms of this Contract and the deletion from the approved list of Members furnished by the Department to Contractor.

Discharge Planning means planning that begins at the time of admission to a hospital or institution to ensure that necessary care, services and supports are in place in the community before individuals leave the hospital or institution in order to reduce readmission rates, improve Member and family preparation, enhance Member

satisfaction, assure post-discharge follow-up, increase medication safety, and support safe transitions.

Disproportionate Share Hospital (DSH) means a health facility licensed pursuant to Health and Safety Code, chapter 2, division 2, to provide acute inpatient hospital services, which is eligible to receive payment adjustments from the State pursuant to Welfare and Institutions Code, section 14105.98.

Dual-Eligible Beneficiary means an individual who is enrolled for benefits under Part A of Title 42 of the United States Code (commencing with Section 1395c) and Part B of Title 42 of the United States Code (commencing with Section 1395j) and is also eligible for medical assistance under the Medi-Cal State Plan.

Eligible Beneficiary means any Medi-Cal beneficiary who is residing in Contractor's Service Area, 55 years of age or older, determined by DHCS as requiring nursing home level of care, and is able to live in a community setting without jeopardizing his or her health or safety, with one of the following aid codes:

Family aid codes 01, 02, 0A, 3E, 3L, 3M, 3N, 3U, 3W, M3
SPD aid codes 20, 23, 24, 26, 27, 36, 60, 63, 64, 66, 67, 2E, 2H, 6A, 6C, 6E, 6H, 6J, 6N, 6P, 6R, 10, 13, 14, 16, 17, 1E, 1H
Adult aid codes 53, 81
Adult Expansion aid codes M1, 7U, L1, L6

Emergency Management Plan means a strategy developed with steps for response and recovery from an unplanned event that could cause death or significant injury to employees, eligible beneficiaries or the public; or that can shut down business, disrupt operations, stop claims payment, cause physical or environmental damage or threaten the facility’s financial standing or public image. Numerous events can be “emergencies” including: fire, hazardous material incident, flood or flash flood, hurricane, tornado, winter storm, earthquake, communications failure, radiological accident, civil disturbance, loss of a key supplier or customer or an explosion.

Encounter means any single medically related service rendered by (a) medical 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 Contractor incurred any financial liability.

Encounter Data means the information that described health care interaction between Members and providers relating to the receipt of any item(s) or service(s) by a Member under this contract and subject to the standards of 42 CFR 438.242 and 438.818.

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

Exhibit E, Attachment 1
Definitions

Enrollment Agreement means a Contract between Contractor and Member which establishes the terms and conditions for Enrollment.

Facility means any premise that is:

A. Owned, leased, used or operated directly or indirectly by or for Contractor or its affiliates for purposes related to this Contract; or

B. Maintained by a provider to provide services on behalf of Contractor.

Federal Financial Participation 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 U.S.C. § 1396d(l)(2)(B)).

Fee-For-Service (FFS) means a method of payment based upon per unit or per procedure billing for services rendered to an Eligible Beneficiary.

Fee-For-Service Medi-Cal means the component of the Medi-Cal Program which Medi-Cal providers are paid directly by the State.

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 as defined by Generally Accepted Accounting Principles (GAAP) which include a Balance Sheet, Income Statement, Statement of Cash Flows, Statement of Equity and accompanying footnotes prepared in accordance with GAAP. All documents are prepared in accordance with GAAP.

Fiscal Year (FY) means any 12-month period for which annual accounts are kept. The State Fiscal Year is July 1 through June 30, and the federal Fiscal Year is October 1 through September 30.

General and Administrative Expenses means expenses as defined in California Code of Regulations, title 28, section 1300.78. These expenses are not part of Allowed Medical Expenses, but are part of Net Capitation Payments.

Exhibit E, Attachment 1
Definitions

Grievance means a complaint, either written or oral, expressing dissatisfaction with service delivery or the quality of care furnished, as defined by the federal PACE regulation 42 CFR Section 460.120.

Health Maintenance Organization (HMO) means an organization that is not a federally qualified HMO, but meets the State Plan's definition of an HMO including the requirements under section 1903(m)(2)(A)(i-vii) of the Social Security Act. An Organization that, through a coordinated system of health care, provides or assures the delivery of an agreed upon set of comprehensive health maintenance and treatment services for an enrolled group of persons through a predetermined periodic fixed prepayment.

Health Plan Employer Data and Information Set (HEDIS) means the set of standardized performance measures sponsored and maintained by the National Committee for Quality Assurance (NCQA).

HEDIS® Compliance Audit means an audit process that uses specific standards and guidelines for assessing the collection, storage, analysis, and reporting of HEDIS® measures. This audit process is designed to ensure accurate HEDIS® reporting.

Indian Health Programs 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 (California Code of Regulations, title 22, section 55000).

Interdisciplinary Team means a team composed of members qualified to fill, at minimum, the following roles, in accordance with 42 CFR 460.102. One individual may fill two separate roles on the interdisciplinary team where the individual meets applicable state licensure requirements and is qualified to fill the two roles and able to provide appropriate care to meet the needs of members:

A. Primary Care Provider;

Primary medical care must be furnished to a member by any of the following:

1) A primary care physician.

2) A community-based physician.

3) A physician assistant who is licensed in the State and practices within his or her scope of practice as defined by State laws with regard to oversight, practice authority and prescriptive authority.

4) A nurse practitioner who is licensed in the State and practices within his or her scope of practice as defined by State laws with regard to oversight, practice authority and prescriptive authority.

B. Registered Nurse;

C. Master's – level Social Worker;

D. Physical Therapist;

E. Occupational Therapist;

F. Recreational Therapist or Activity Coordinator;

G. Dietician;

H. PACE Center Manager;

I. Home Care Coordinator;

J. Personal Care Attendant or his or her representative; and

K. Driver or his or her representative

Integrated Systems of Care Division (ISCD) means the division within DHCS that manages and monitors the Contract.

Intermediate Care Facility (ICF) means a Facility that is licensed as an ICF by DHCS or a hospital or Skilled Nursing Facility which meets the standards specified in California Code of Regulations, title 22, section 51212 and has been certified by DHCS for participation in the Medi-Cal program.

Joint Commission on the Accreditation of Health Care Organizations (JCAHO) means the organization composed of representatives of the American Hospital Association, the American Medical Association, the American College of Physicians, the American College of Surgeons, and the American Dental Association. JCAHO provides health care accreditation and related services that support performance improvement in health care organizations.

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

Exhibit E, Attachment 1
Definitions

Marketing means any activity conducted by or on behalf of Contractor where information regarding the services offered by 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 Contractor.

Marketing Materials means materials produced in any medium, by or on behalf of the Contractor that can reasonably be interpreted as intended to market to potential enrollees.

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

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

Medical Expenses means Contractor's actual expenses incurred and accounted for in accordance with the Generally Accepted Accounting Principles for Covered Services delivered to Members during each period. This includes expenses incurred for provider payment incentive programs, medical management, utilization management and quality assurance activities, but excludes administrative costs as defined in California Code of Regulations title 28, section 1300.78 as well as pass-through items such as intergovernmental transfers, Hospital Quality Assurance Fees, and MCO/Sales taxes.

Medical Loss Ratio (MLR) means the Allowed Medical Expenses for the covered services provided to enrollees under the Contract divided by the amount of Medi-Cal managed care Net Capitation Payments or revenues recorded by Contractor, by county. The MLR will be measured by the same county that was used in the development of the capitation rates paid to the Contractor, under this Contract. The calculation excludes both the portion of Contractor's capitation revenues and associated expenses for items such as intergovernmental transfers, Hospital Quality Assurance Fees, MCO/Sales taxes, and the Health Insurance Providers Fee (HIPF).

If a Staff Model Contractor does not account for Medical Expenses specifically by line of business and uses an allocation methodology, the MLR shall be the average MLR of all other Medi-Cal managed care contractors operating within the county in which Contractor operates. In such cases, Staff Model Contractor's MLR shall be excluded from the average MLR.

Medi-Cal Managed Care Division means the division within the DHCS that has the responsibility, along with ISCD, for monitoring managed care Contracts.

Exhibit E, Attachment 1
Definitions

Medical Records means written documentary evidence of treatments rendered to plan Members.

Medically Necessary or **Medical Necessity** means reasonable and necessary 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.

Member means any Eligible Medi-Cal Beneficiary who has enrolled in Contractor's plan in accordance with the provisions of California Code of Regulations title 22, section 53420. 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.

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

Net Capitation Payments means Contractor’s capitation revenues less designated amounts included in capitation rates that Contractor is required to pay to providers, such as for intergovernmental transfers and HQAFs, and the State, such as for Contractor premium/Sales taxes, Hospital Quality Assurance Fees, and the Health Insurance Providers Fee (HIPF). Net Capitation Payments shall exclude retroactive adjustments relating to the prior service period(s) and shall include amounts accrued/recognized for the service period in accordance with Generally Accepted Accounting Principles (GAAP).

Non-Emergency Medical Transportation means ambulance, litter van and wheelchair van medical transportation services when the Member’s medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for the purpose of obtaining needed medical care, per California Code of Regulations title 22, sections 51323, 51231.1 and 51231.2 rendered by licensed providers.

Non-Medical Transportation means transportation of Members to medical 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.

Exhibit E, Attachment 1
Definitions

Non-Physician Medical Practitioners (Mid-Level Practitioner) means a nurse practitioner or Physician assistant authorized to provide Primary Care under Physician supervision.

Not Reported means: 1) Contractor calculated the measure but the result was materially biased; 2) Contractor did not calculate the measure even though a population existed for which the measure could have been calculated; and/or, 3) Contractor calculated the measure but chose not to report the rate.

Nurse means a person licensed by the California Board of Nursing as, at least, a Registered Nurse (RN).

Nursing Facility Level of Care means the Level of Care meeting criteria established in the department's approved Medi-Cal Manual of Criteria for Medi-Cal Authorization that includes California Code of Regulations, title 22, sections 51334 and 51335.

Other Healthcare Coverage Sources (OHCS) means the responsibility of an individual or entity, other than Contractor or the Member, for the payment of the reasonable value of all or part of the healthcare benefits provided to a Member. Such OHCS may originate under any other State, federal or local medical care program or under other contractual or legal entitlement, including, but not limited to, a private group or indemnification program. This responsibility may result from a health insurance policy or other contractual agreement or legal obligation, excluding Tort Liability.

Outpatient Care means treatment provided to a Member who is not confined in a health care Facility.

Outpatient Mental Health Services means outpatient services that Contractor will provide for Members with mild to moderate mental health conditions including: individual or group mental health evaluation and treatment (psychotherapy); psychological testing when clinically indicated to evaluate a mental health condition; psychiatric consultation for medication management; and outpatient laboratory, supplies, and supplements.

PACE stands for the Program of All-Inclusive Care for the Elderly.

PACE Center means the location designated by Contractor at which Members shall receive PCP services.

PACE Organization means an organization which meets the requirements of 42 CFR Section 460.60, and all other state and federal statutes and regulations applicable to PACE plans, and has signed a PACE Program agreement DHCS.

Exhibit E, Attachment 1
Definitions

Person-Centered Planning means an ongoing process designed to develop an individualized care plan specific to each person's abilities and preferences.

Physician means a person duly licensed as a Physician by the Medical Board of California.

Physician Incentive Plan means any compensation arrangement between Contractor and a Physician or a Physician group that may not directly or indirectly have the effect of reducing or limiting services provided to Members under this Contract.

Policy Letter means a document that has been dated, numbered, and issued by the MMCD or ISCD that clarifies regulatory or contractual requirements.

Policy Statement means a detailed goal statement in which Contractor commits to meet all aspects of this Contract.

Post-Payment Recovery means Contractor pays the provider for the services rendered and then uses all reasonable efforts to recover the cost of the services from all liable third parties.

Post Stabilization Care means services provided subsequent to an emergency that a treating physician views as medically necessary after an emergency medical condition has been stabilized. They are not emergency services, which POs are obligated to cover. Rather, they are non-emergency services that the PO should approve before they are provided outside the service area.

Preventive Care means health care designed to prevent disease and/or its consequences.

Primary Care means a basic level of health care usually rendered in ambulatory settings by general practitioners, family practitioners, internists, obstetricians, pediatricians, and mid-level practitioners. This type of care emphasizes caring for the Member's general health needs as opposed to specialists focusing on specific needs.

Primary Care Dentist means a dentist responsible for supervising, coordinating, and providing dental care to Member.

Primary Care Physician (PCP) means a Physician responsible for supervising, coordinating, and providing initial and Primary Care to patients and serves as the medical home for Members The PCP is general practitioner, internist, pediatrician, family practitioner, or who obstetrician/gynecologist (OB/GYN).

Exhibit E, Attachment 1
Definitions

Primary Care Provider (PC) means a person responsible for supervising, coordinating, and providing initial and Primary Care to patients; for initiating referrals; and, for maintaining the continuity of patient care. A Primary Care Provider may be a PCP or Non-Physician Medical Practitioner.

Prior Authorization means a formal process requiring a health care provider to obtain advance approval to provide specific services or procedures, or the process by which an IDT approves a member to receive a specific service or procedure.

Provider Grievance means an oral or written expression of dissatisfaction, including any complaint, dispute, request for reconsideration or appeal made by a provider. DHCS considers complaints and appeals the same as a grievance.

Prior Authorization Request means a method by which practitioners seek approval from Contractor to render medical services. Contractor's IDT is responsible for granting approval to providing specific, non-emergency medical services in advance of rendering such services.

Procedures means a detailed description of how Contractor and its designees will achieve the goal. It will contain details of systems, processes, and lines of communication integral to achieving the policy as stated in Contractor’s Policy and Procedures manuals.

Program Director means a person responsible for oversight and administration of the entity as specified by 42 CFR Section 460.60(b).

Protocols means a written plan of delivery of services and must identify how the services are delivered for standard, consistent care to Members.

Provider of Services means any individual, partnership, clinic, group, association, corporation, institution or public agency meeting applicable standards for participation with the Medi-Cal program as defined in California Code of Regulations title 22, section 51200 et seq..

Provider Appeal means an Appeal concerning the authorization or denial of a service, denial, deferral or modification of a Prior Authorization request on behalf of a Member or the processing of a payment or non-payment of a claim by the Contractor.

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 health services and administrative and support services.

Exhibit E, Attachment 1
Definitions

Quality Improvement (QI) means the result of an effective Quality Improvement System.

Quality Improvement System (QIS) means systematic activities to monitor and evaluate the medical care delivered to Members according to the standards set forth in regulations and contract language. Contractor must have processes in place, that measure the effectiveness of care, identifies problems, and implements improvement on a continuing basis.

Quality of Care means the degree to which health services for individuals and populations increases the likelihood of desired health outcomes and are consistent with current professional knowledge.

Quality Incidents means an unexpected occurrence that caused a Member death or serious physical or psychological injury that included permanent loss of function. Included in this definition are any medical equipment failures that could have caused a death and all attempted suicides.

Quality Indicators means measurable variables relating to a specific clinic or health services delivery area which are reviewed over a period of time to screen delivered health care and to monitor the process or outcome of care delivered in that clinical area.

Reinsurance means coverage secured by Contractor, which limits the amount of risk or liability assumed under this Contract.

Rural Health Clinic (RHC) means an entity defined in California Code of Regulations title 22, section 51115.5.

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

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

Sensitive Services means those services related to:

A. Sexually transmitted diseases (STDs)

Exhibit E, Attachment 1
Definitions

B. HIV testing

Screening, Brief Intervention, and Referral to Treatment (SBIRT) means services provided by a PCP to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol.

Service Area means the county or counties in which Contractor is approved to operate 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 at which a Member obtains any health care services provided by Contractor under the terms of this Contract.

Skilled Nursing Facility (SNF) means, as defined in California Code of Regulations title 22, section 51121(a), any institution, place, building or agency which is licensed as a SNF by DHCS or is a distinct part or unit of a hospital, meets the standard specified in Section 51215 of these regulations (except that the distinct part of a hospital does not need to be licensed as a SNF) and has been certified by DHCS for participation as a SNF in the Medi-Cal program. Section 51121(b) further defines the term "Skilled Nursing Facility" as including terms "skilled nursing home," "convalescent hospital," "nursing home," or "nursing facility".

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

Specialty Mental Health Service means those services identified in 9 CCR section 1810.247, including but not limited to:

A. Rehabilitative Mental Health Services, including:

   a. Mental health services;

   b. Medication support services;

   c. Day treatment intensive;

   d. Day rehabilitation;

   e. Crisis intervention;

Exhibit E, Attachment 1
Definitions

f. Crisis stabilization;

g. Adult residential treatment services;

h. Crisis residential treatment services;

i. Psychiatric health facility services;

j. Psychiatric Inpatient Hospital Services;

k. Targeted Case Management;

l. Psychiatrist Services;

m. Psychologist Services;

n. EPSDT Supplemental Specialty Mental Health Services; and

o. Psychiatric Nursing Facility Services.

State means the State of California.

State Officer means

A U.S. Senator or member of Congress representing California

The Governor

The Lieutenant Governor

The Secretary of State

The Controller

The Treasurer

The Attorney General

The State Superintendent of Public Instruction; or

A member of the Legislature

Exhibit E, Attachment 1
Definitions

Subacute Care means, as defined in California Code of Regulations, title 22 section 51124.5, a level of care needed by a patient who does not require hospital acute care but who requires more intensive licensed skilled nursing care than is provided to the majority of patients in a SNF.

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

A. A provider of health care services who agrees to furnish Covered Services to Members.; and

B. Any other organization or person(s) who agree(s) to perform any administrative function or service for Contractor specifically related to fulfilling Contractor's obligations to DHCS under the terms of this Contract.

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

Supplemental Security Income (SSI) means the program authorized by Title XVI of the Social Security Act (42 U.S.C. §§ 1381-1383f) for aged, blind, and disabled persons.

Telehealth means a method of delivering health care services by using information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a Member's health care while the Member is at a separate location from the health care provider. Telehealth facilitates the Member's self-management and caregiver support for the Member.

Third Party Tort Liability (TPTL) means the responsibility of an individual or entity other than Contractor or the Member for the payment of claims for injuries or trauma sustained by a Member. This responsibility may be contractual, a legal obligation or as a result of, or the fault or negligence of, third parties (e.g., auto accidents, other personal injury casualty claims, or Workers' Compensation Appeals).

Unusual Incident or Injury means one which threatens the welfare, safety or health of any Member, and which is not consistent with the Center's routine operation or Member care. Any incident that meets the level one and level two criteria established by the CMS HPMS reporting guidelines, regardless of where it occurred, must be reported.

Unusual or Seldom-Used Health Care Services means those services of which 12 or fewer transactions are performed by Contractor in any one year period.

Exhibit E, Attachment 1
Definitions

Urgent Care means on-site services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury (i.e., sore throats, fever, minor lacerations, and some broken bones). Off-site Urgent care, as defined by federal PACE regulation 42 CFR 460.100(e)(3), means the care provided to a PACE member who is out of the PACE Service Area, and who believes his or her illness or injury is too severe to postpone treatment until they return to the Service Area, but their life or function is not in severe jeopardy.

Utilization means the rate patterns of service usage or types of service occurring within a specified time. Inpatient Utilization is generally expressed in rates per unit of population-at-risk for a given period; e.g., the number of hospital admissions per 1,000 persons enrolled in an HMO/per year.

Utilization Review means the process of evaluating the necessity, appropriateness, and efficiency of the use of medical services, procedures and Facilities.

Working day(s) means State calendar (State Appointment Calendar, Standard 101) working day(s).

Exhibit E, Attachment 2
Program Terms and Conditions

1. Governing Law

In addition to Exhibit C, provision 14, 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 16. Sanctions, and provision 17. Liquidated Damages below, the parties agree that any remedies for DHCS' or Contractor's non-compliance with laws not expressly incorporated into this Contract or any covenants implied to be part of this Contract, shall not include money damages, but may include equitable remedies such as injunctive relief or specific performance. In the event any provision of this Contract is held invalid by a court, the remainder of this Contract shall not be affected. 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.

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

Such amendment shall constitute grounds for termination of this Contract in accordance with the procedures and provisions of provision 14. paragraph C., Termination – Contractor below. The parties shall be bound by the terms of the amendment until the effective date of the termination.

B. All existing final Policy Letters issued by MMCD and ISCD applicable to PACE can be viewed at www.dhcs.ca.gov/formsandpubs/Pages/PolicyLetters.aspx and shall be complied with by Contractor. All Policy Letters issued by MMCD and ISCD, applicable to PACE, subsequent to the effective date of this Contract shall provide clarification of Contractors obligations pursuant to this Contract, and may include instructions to Contractor regarding implementation of mandated obligations pursuant to changes in state or federal statutes or regulations, or pursuant to judicial interpretation.

In the event DHCS determines that there is an inconsistency between this Contract and a Policy Letter, the Contract shall prevail.

2. Entire Agreement

This written Contract and any amendments shall constitute the entire agreement between the parties. No oral representations shall be binding on either party unless such representations are reduced to writing and made an amendment to the Contract.

3. Amendment Process

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. No amendment will be considered binding on either party until it is formally approved by the both parties and the Department of General Services (DGS), if DGS approval is required.

4. Cancellation / Termination

A. This Agreement may be cancelled by DHCS without cause upon 30 calendar days advance written notice to the Contractor.

B. DHCS reserves the right to cancel or terminate this Agreement immediately for cause. The Contractor may submit a written request to terminate this Agreement only if DHCS substantially fails to perform its responsibilities as provided herein.

C. The term “for cause” shall mean that the Contractor fails to meet the terms, conditions, and/or responsibilities of this Agreement.

D. Agreement termination or cancellation shall be effective as of the date indicated in DHCS’ notification to the Contractor. The notice shall stipulate any final performance, invoicing or payment requirements.

E. In the event of early termination or cancellation, the Contractor shall be entitled to payment for all allowable costs authorized under this Agreement and incurred up to the date of termination or cancellation, including authorized

non-cancelable obligations, provided such expenses do not exceed the stated maximum amounts payable.

5. Change Requirements

A. General Provisions

The parties recognize that during the life of this Contract, the Integrated Systems of Care Division and Medi-Cal Managed Care Program shall be a dynamic program requiring numerous changes to its operations and that the scope and complexity of changes shall vary widely over the life of the Contract. The parties agree that the development of a system that has the capability to implement such changes in an orderly and timely manner is of considerable importance.

B. Contractor's Obligation to Implement

The Contractor will make changes mandated by DHCS. In the case of mandated changes in regulations, statutes, Federal guidelines, or judicial interpretation, DHCS may direct the Contractor to immediately begin implementation of any change by issuing a change order. If DHCS issues a change order, the Contractor will be obligated to implement the required changes while discussions relevant to any capitation rate adjustment, if applicable, are taking place. DHCS may, at any time, within the general scope of the Contract, by written notice, issue change orders to the Contract.

C. Moral or Religious Objections to Providing a Service

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

6. Delegation of Authority

A. DHCS intends to implement this Contract through a single administrator, called the "Contracting Officer". The Director of DHCS shall appoint the Contracting Officer. The Contracting Officer, on behalf of DHCS, shall make all determinations and take all actions as are appropriate under this Contract, subject to the limitations of applicable federal and state laws and

regulations. The Contracting Officer may delegate his/her authority to act to an authorized representative through written notice to Contractor.

B. Contractor shall designate a single administrator; hereafter called the "Contractor's Representative". Contractor's Representative, on behalf of Contractor, shall make all determinations and take all actions as are appropriate to implement this Contract, subject to the limitations of the Contract, federal and state laws and regulations. Contractor's Representative may delegate his or her authority to act to an authorized representative through written notice to the Contracting Officer. Contractor's Representative shall be empowered to legally bind Contractor to all agreements reached with DHCS.

C. Contractor shall designate Contractor's Representative in writing and shall notify the Contracting Officer, in accordance with Exhibit E, Attachment 2, provision 10.

7. Authority of the State

Sole authority to establish, define or determine the reasonableness, the necessity and level and scope of covered benefits under the PACE program administered in this Contract or coverage for such benefits or the eligibility of the beneficiaries or providers to participate in the PACE resides with DHCS.

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

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.

8. Fulfillment of Obligations

No covenant, condition, duty, obligation or undertaking continued or made a part of this Contract shall be waived except by written agreement of the parties hereto, and forbearance or indulgence in any other form or manner by either party in any regard whatsoever shall 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 shall have the right to invoke any remedy available under this Contract or under law, notwithstanding such forbearance or indulgence.

9. Obtaining DHCS Approval

Contractor shall obtain written approval from DHCS in Exhibit E, Attachment 3, provision 5. Approval Process, prior to implementing, amending or using any of the following:

A. Providers of medical and dental covered services, except for providers of seldom used or unusual services as determined by the DHCS;

B. Facilities and site expansions;

C. Subcontracts and sub-subcontracts with providers or management services;

D. Marketing activities;

E. All Marketing materials, promotional materials, and public information releases relating to performance under this Contract, Enrollment Agreement: Terms and Conditions, and Member newsletters;

F. Member Grievance procedure, including forms;

G. Member Enrollment and Disenrollment procedures, including forms;

H. Utilization control mechanism, including a description of the system to evaluate the quality of medical and dental care, conduct professional review activities, assess the performance of medical personnel, and monitor utilization and cost effectiveness;

I. Any other protocol, policy or procedure requiring approval under this Contract; and

J. Any deviation or change from the approved organizational structure.

10. Certifications

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

In addition to Exhibit C, provision 11, Contractor also agrees to the following:

With respect to any report, invoice, record, papers, documents, books of account or other Contract required data submitted, pursuant to the requirements of this Contract, Contractor's Representative or his or her designee shall certify, under penalty of perjury, that the report, invoice, record, papers, documents, books of account or other Contract required data is current, accurate, complete and in full compliance with legal and contractual requirements to the best of that individual's knowledge and belief, unless the requirement for such certification is expressly waived by DHCS in writing.

11. Notices

A. All Notices

All notices to be given under this Contract shall be in writing and shall be deemed to have been given when mailed to DHCS or Contractor at the following addresses:

Chief, Integrated Systems of Care Division
[PACE Plan Name]
Department of Health Care Services
1501 Capitol Avenue, MS 4502
P.O. Box 997437
Sacramento, CA 95899-7437

dba: PACE Plan Name
Address
city, CA zip code

B. Notification of Intent Not to Renew

Should either party elect not to renew this Contract, this decision shall be conveyed in writing to the other party at least 90 days prior to the expiration of this Contract.

12. Term

The Contract shall become effective July 1, 2020, and shall continue in full force and effect through December 31, 2024 subject to the provisions of Exhibit B, provision 1, CMS waiver approval, and Exhibit D(F), provision 9. Federal Contract Funds.

13. Service Area

Contractor must serve a defined Service Area, identified by zip codes, approved by DHCS and CMS. Changes in the Service Area must be pre-approved by

DHCS and CMS.

14. Contract Extension

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

Contractor shall provide written notification to DHCS of its intent to accept or reject the extension within five state working days of the receipt of the notice from DHCS.

15. Termination for Cause and Other Terminations

In addition to Exhibit C, provision 7, Contractor also agrees to the following:

A. Termination – State or Director

DHCS may terminate performance of work under this Contract in whole, or in part, whenever for any reason DHCS determines that the termination is in the best interest of the state.

1) DHCS shall notify Contractor of intent to terminate the contract at least six (6) months prior to the effective date of termination, except in cases described below in Paragraph B. Termination for Cause.

2) If DHCS awards a new contract for one or more of the Service Areas to another Contractor during one of the amendment periods as described above in provision 13. Contract Extension, DHCS shall provide the Contractor written notification at least six (6) months prior to termination to allow for all Phaseout Requirements to be completed.

B. Termination for Cause

1) DHCS shall terminate this Contract pursuant to the provisions of Welfare and Institutions Code, Section 14304(a) and Title 22 CCR Section 53873.

2) DHCS may terminate this Contract as stated in 42 USC Section 1395eee(e)(5)(B), and 42 CFR 460.50, including but not limited to:

   a) Either DHCS determines there are significant deficiencies in the quality of care provided to enrolled members, or the Contractor has failed to comply substantially with conditions for a program or provider under this section or Section 1396u-4 of this title; and

   b) Contractor has failed to develop and successfully initiate, within 30 days of the date of the receipt of written notice of such a determination, a plan to correct the deficiencies, or has failed to continue implementation of such a plan.

3) Notification shall be given at least six months prior to the effective date of termination, except in cases described below in Paragraph C.

4) DHCS shall terminate this Contract in the event that: the Secretary, DHHS, determines that Contractor does not meet the requirements for participation in the Medicaid program, Title XIX of the Social Security Act. Notification will be given by DHCS at least 60 calendar days prior to the effective date of termination.

5) In cases where the Director determines the health and welfare of Members is jeopardized by continuation of the Contract, the Contract shall be immediately terminated. Notification will state the effective date of, and the reason for, the termination.

Except for termination pursuant to Paragraph B., item 2) above, Contractor may dispute the termination decision through the dispute resolution process pursuant to Provision 18. Termination of this Contract shall be effective on the last day of the month in which the Secretary or DHHS makes such determination, provided that DHCS provides Contractor with at least 60 calendar days' notice of the termination. The termination of this Contract shall be effective on the last day of the second full month from the date of the notice of termination. Contractor agrees that 60 calendar days**'** notice is reasonable. Termination under this section does not relieve Contractor of its obligations under Provision 15 below. Phaseout Requirements shall be performed after Contract termination.

C. Termination - Contractor

Grounds under which Contractor may terminate this Contract are limited to: (1) Unwillingness to accept the Capitation Rates determined by DHCS, or if DHCS decides to negotiate rates, failure to reach mutual agreement on rates; or (2) When a change in contractual obligations is created by a state or federal change in the Medi-Cal program or a lawsuit, that substantially alters the financial assumptions and conditions under which 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.

If Contractor invokes ground number 2, Contractor shall submit a detailed written financial analysis to DHCS supporting its conclusions that it cannot remain financially solvent. At the request of DHCS, Contractor shall submit or otherwise make conveniently available to DHCS, all of Contractor's financial work papers, financial reports, financial books and other records, bank statements, computer records, and any other information required by DHCS to evaluate Contractor's financial analysis.

For any Contract termination initiated by the Contractor, the Contractor must provide at least 90 days prior notice to CMS and DHCS, and at least 60 days prior notice to members.

DHCS and Contractor may negotiate an earlier termination date if Contractor can demonstrate to the satisfaction of DHCS that it cannot remain financially solvent until the termination date that would otherwise be established under this section. Termination under these circumstances shall not relieve Contractor from performing the Phaseout Requirements described in Provision 15 below.

D. Termination of Obligations

All obligations to provide Covered Services under this Contract or Contract extension shall automatically terminate on the effective date of any termination of this Contract pursuant to sections A, B, or C of this provision or upon expiration of the term of this Contract. Contractor shall be responsible for providing Covered Services to Members until the termination or expiration of this Contract and shall remain liable for the processing and payment of invoices and statements for Covered Services provided to Members prior to such expiration or termination. All eligible Medi-Cal beneficiaries shall be transferred to a fee-for-service or other

appropriate service status when this Contract has been terminated. The Contractor shall provide assistance to the individual in obtaining necessary transitional care through appropriate referrals and making the individual's medical records available to new providers.

E. Notice to Members of Transfer of Care

Contractor shall develop and implement a detailed written plan for phase-down in the event of termination which includes the process for informing Members, the community, CMS and the state in writing about termination and transition procedures; and steps that shall be taken to help assist Members to obtain reinstatement of conventional Medi-Cal benefits, transition their care to other providers, and terminate Marketing and Enrollment activities. At least 60 days prior to the proposed termination date of the Contract, Contractor must submit the detailed written plan for phase-down to DHCS for approval prior to implementation by the Contractor. Contractor must modify the detailed written plan for phase-down to obtain approval by DHCS.

16. Phaseout Requirements

A. DHCS shall withhold the lesser of an amount equal to 10% of the last month’s Service Area capitation payment or one million dollars ($1,000,000) for each Service Area unless provided otherwise by the Financial Performance Guarantee, from the capitation payment of the last month of the Operations Period for each Service Area until all activities required during the Phase-out Period for each Service Area are fully completed to the satisfaction of DHCS, in its sole discretion.

If all Phase-out activities for each Service Area are completed by the end of the Phase-out Period, the withhold will be paid to the Contractor. If the Contractor fails to meet any requirement(s) by the end of the Phaseout Period for each Service Area, DHCS will deduct the costs of the remaining activities from the wirthhold amount and continue to withhold payment until all activities are completed.

B. The objective of the Phase-out 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. The Contractor shall not provide services to Members during the Phase-out Period.

90 calendar days prior to termination or expiration of this Contract and through the Phase-out Period for each Service Area, the Contractor shall assist DHCS in the transition of Members and in ensuring, to the extent possible, continuity of Member-Provider relationships. In doing this, the Contractor will make available to DHCS copies of Medical Records, patient files, and any other pertinent information, including information maintained by any subcontractor, necessary for efficient case management of Members, as determined by the Director. Under no circumstances will a Medi-Cal Member be billed for this activity.

C. Phase-out for this Contract shall consist of the processing, payment and monetary reconciliation(s) necessary regarding claims for payment for Covered Services.

Phase-out for the Contract shall 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 in Exhibit A, Attachment 17, for the period from the last submitted report through the expiration or termination date.

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

D. Phase-out Period will commence on the date the Operations Period of the Contract or Contract extension ends. Phase-out related activities are non-payable items.

17. Sanctions

If, as set forth in 42 CFR 460.42(b)(2), CMS denies medical assistance payment to DHCS for services furnished under this Contract based on the Contractor committing one or more violations specified in 42 CFR 460.40, then DHCS shall not be responsible for payment to Contractor in the amount of the CMS denial, and DHCS may recover any overpayment from Contractor based on the CMS payment denial either through an offset or direct reimbursement from Contractor.

Contractor is subject to sanctions and civil penalties taken pursuant to 42 CFR 460.4, 460.40 through 460.54, and 460.194 Welfare and Institutions Code Section 14304 and California Code of Regulations, title 22, section 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.

A. In the event DHCS finds Contractor non-compliant with any provisions of this Contract, applicable statutes or regulations, DHCS may impose sanctions provided in Welfare and Institutions Code, section 14304 and California Code of Regulations title 22, section 53872 as modified for purposes of this Contract. California Code of Regulations, title 22, section 53872 is so modified as follows

   1) Subsection (b)(1) is modified by replacing “Article 2” with “Article 6”

   2) Subsection (b)(2) is modified by replacing “Article 3” with “Article 7”

B. The requirements of Exhibit A, Attachment 4, regarding QIS are all Contract provisions which are not specifically governed by Chapter 4.1 (commencing with Section 53800) of Division 3 of title 22, CCR. Therefore, sanctions for violations of the requirements of Exhibit A, Attachment 4, regarding QIS shall be governed by Subsection 53872 (b)(4).

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

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

   2) In the case of Exhibit A, Attachment 4 Quality Improvement System, the Contractor consistently fails to achieve the minimum performance levels, or receives a “Not Reported” designation on an External Accountability Set measure, after implementation of Corrective Actions.

   3) A substantial failure to provide medically necessary services required under this Contract or law to a Member.

   4) Non-compliance with the Contract or applicable federal and state law or regulation.

   5) Contractor has accrued claims that have not or will not be recompensed. D. Sanctions in the form of denial of payments

provided for under the contract for new enrollees shall be taken, when and for as long as, payment for those enrollees is denied by CMS under 42 CFR 438.730.

E. The Director shall have the power and authority to take one or more of the following sanctions against Contractor for noncompliance:

1) Appointment of temporary management if Contractor has repeatedly failed to meet the contractual requirements or applicable Federal and state law or regulation. Contractor cannot delay appointment of temporary management to provide a hearing before appointment. Temporary management will not be terminated until DHCS determines that Contractor's sanctioned behavior will not recur.

2) Suspension of all new enrollment, including default enrollment, or marketing activities after the effective date of the sanction;

3) Require Contractor to temporarily suspend or terminate personnel or subcontractors.

4) Take other appropriate action as determined necessary by DHCS.

18. Liquidated Damages

A. General

The Director shall have the authority to impose liquidated damages on Contractor for failure to comply with the terms of this Contract as well as all applicable Federal and state law or regulation. Therefore, it is agreed by the state and Contractor that:

1) If Contractor does not provide or perform the requirements of this Contract or applicable laws and regulations, damage to the state shall result:

a. Proving such damages shall be costly, difficult, and time-consuming;

b. Should the state choose to impose liquidated damages, Contractor shall pay the state those damages for not providing or performing the specified requirements;

c. Additional damages may occur in specified areas by prolonged periods in which Contractor does not provide or perform requirements;

d. The damage figures listed below represent a good faith effort to quantify the range of harm that could reasonably be anticipated at the time of the making of the Contract;

e. DHCS may, at its discretion, offset liquidated damages from Capitation Payments owed to Contractor.

2) Imposition of liquidated damages as specified in paragraphs B. and C., below shall follow the administrative processes described below.

3) Before imposing sanctions, DHCS shall provide Contractor with written notice specifying the nature of the sanctions and the Contractor requirement(s), contained in the Contract or as required by federal and state law or regulation, not provided or performed,

4) Contractor shall demonstrate the provision or performance of Contractor's requirement(s) specified in the written notice within a 30 calendar day Corrective Action period from the date of the notice, unless a request for an extension is submitted to the Contracting Officer, subject to DHCS' approval, within five calendar days from the end of the Corrective Action period. If Contractor has not demonstrated the provision or performance of Contractor's requirement(s) specified in the written notice during the Corrective Action period, DHCS may impose liquidated damages for each day the specified Contractor's requirement is not performed or provided for the amount specified in paragraph C below.

5) If Contractor has not performed or provided Contractor's requirement(s) specified in the written notice or secured the written approval for an extension, after 30 calendar days from the first day of the imposition of liquidated damages, DHCS shall notify Contractor in writing of the increase of the liquidated damages to the amount specified in paragraph C. below.

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 11 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.

The terms and sanctions provided in W&I Code section 14197.7 shall apply to PACE plans.

C. Liquidated Damages for Violation of Contract Terms or Regulations shall at a minimum include:

1) DHCS may impose liquidated damages of $2,500 per day for each violation of Contract requirement not performed in accordance with Exhibit A, Attachment 4, Quality Improvement System, provision 10 and / or paragraph D., until Contract requirement is performed or provided.

2) DHCS may impose liquidated damages of $3,500 per instance or case, per Medi-Cal Member if a Contractor fails to deliver the requested information in accordance with provision 23.

3) DHCS may impose liquidated damages of $3,500 per violation of Contract requirement not performed in accordance with Exhibit A, Attachment 6, provision 9.

4) DHCS may impose liquidated damages not to exceed $10,000 per violation of this Contract's requirements, as well federal and state law or regulation.

D. Conditions for Termination of Liquidated Damages

Except as waived by the Contracting Officer, no liquidated damages imposed on the Contractor will be terminated or suspended until the Contractor issues a written notice of correction to the Contracting Officer certifying, under penalty of perjury, the correction of condition(s) for which

liquidated damages were imposed. Liquidated damages will cease on the day of the Contractor's certification only if subsequent verification of the correction by DHCS establishes that the correction has been made in the manner and at the time certified to by the Contractor.

The Contracting Officer will determine whether the necessary level of documentation has been submitted to verify corrections. The Contracting Officer will be the sole judge of the sufficiency and accuracy of any documentation. Corrections must be sustained for a reasonable period of at least 90 calendar days from DHCS acceptance; otherwise, liquidated damages may be reimposed without a succeeding grace period within which to correct. The Contractor's use of resources to correct deficiencies will not be allowed to cause other Contract compliance problems.

E. Severability of Individual Liquidated Damages Clauses

If any portion of these liquidated damages provisions is determined to be unenforceable, the other portions will remain in full force and effect.

19. Disputes

In addition to Exhibit C, provision 6, Contractor also agrees to the following:

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

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

A. Disputes Resolution by Negotiation

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

Before issuance of a Contracting Officer’s decision, informal discussions between the parties by individuals who have not participated substantially

in the matter in dispute shall be considered by the parties in efforts to reach mutual agreement.

B. Notification of Dispute

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

Contractor's notification shall state, on the basis of the most accurate information then available to 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 Contractor is disputing the conduct;

6) The cost impact to Contractor directly attributable to the alleged conduct, if any;

7) Contractor's desired remedy.

The required documentation, including cost impact data, shall 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, Contractor will comply with the requirements of California Code of Regulations, title 22, section 53851 (d) and diligently continue performance of this Contract, including matters identified in the Notification of Disputes, to the maximum extent possible.

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

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

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

   a. Countermand the earlier conduct which caused Contractor to file a dispute; or

   b. Reaffirm the conduct and, if there is a cost impact sufficient to constitute a change in obligations pursuant to the payment provisions contained in Exhibit B, direct DHCS to comply with that Exhibit; or

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

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

   A copy of the decision shall be served on Contractor.

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

Contractor shall have 30 calendar days following the receipt of the decision to file an Appeal of the decision to the Director. All Appeals shall be governed by Health and Safety Code section 100171, except for those provisions of Section 100171, subdivision(d), criteria(1) relating to accusations, statements of issues, statement to respondent, and notice of defense. All Appeals shall be in writing and shall be filed with DHCS' Office of Administrative Hearings and Appeals. An Appeal shall be deemed filed on the date it is received by the Office of Administrative Hearings and Appeals. An Appeal shall specifically set forth each issue in dispute, and include Contractor's contentions as to those issues. However, Contractor's Appeal shall be limited to those issues raised in its Notification of Dispute filed pursuant to paragraph B, Notification of Dispute above. Failure to timely Appeal the decision shall constitute a waiver by Contractor of all claims arising out of that conduct, in accordance with paragraph F, Waiver of Claims below. Contractor shall exhaust all procedures provided for in this provision 18, prior to initiating any other action to enforce this Contract.

E. Contractor Duty to Perform

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

If pursuant to an Appeal under paragraph D. Appeal of Contracting Officer’s or Alternate Dispute Officer’s Decision, the Contracting Officer’s or alternate dispute officer’s decision is reversed, the effect of the decision pursuant to paragraph D. shall be retroactive to the date of the 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.

F. Waiver of Claims

If Contractor fails to submit a Notification of Dispute, supporting and substantiating documentation, any additionally required information, or an Appeal of the Contracting Officer's or alternate dispute officer's decision, in the manner and within the time specified in this provision 18, that failure

shall constitute a waiver by Contractor of all claims arising out of that conduct, whether direct or consequential in nature.

20. Audit

In addition to Exhibit C, provision 4, Contractor also agrees to the following:

Contractor shall maintain such books and records necessary to disclose how Contractor discharged its obligations under this Contract. These books and records shall disclose the quantity of Covered Services provided under this Contract, the quality of those services, the manner and amount of payment made for those services, the persons eligible to receive Covered Services, the manner in which Contractor administered its daily business, and the cost thereof.

A. 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 working papers, reports submitted to DHCS, financial records, all Medical Records, medical charts and prescription files, and other documentation pertaining to medical and non-medical services rendered to Members.

B. Records Retention

Notwithstanding any other records retention time period set forth in this Contract, these books and records shall be maintained for a minimum of ten years from the final date of the Contract period or from the date of completion of any audit, whichever is later.

Additional Recordkeeping Requirements:

1) In accordance with 42 CFR 438.3(u), Contractor shall retain the following information for no less than 10 years:

    a. Member Grievance and Appeal records;

    b. Base data;

    c. MLR reports; and

    d. Data, information

Exhibit E, Attachment 2
Program Terms and Conditions

21. Inspection Rights

In addition to Exhibit D(F), provision 2, Contractor also agrees to the following:

Through the end of the records retention period specified in Provision 19, Audit, Paragraph B., above, Contractor shall allow the DHCS, DHHS, the Comptroller General of the United States, Department of Justice (DOJ), Bureau of Medi-Cal Fraud, DMHC, and other authorized state agencies or their duly authorized representatives or designees, including DHCS' external quality review organization contractor, 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 premises, books, records, Facilities, contracts, computers or other electronic systems, maintained by Contractor and Subcontractors, pertaining to such services at any time.

Records and documents include, but are not limited to, all physical records originated or prepared pursuant to the performance under this Contract including working papers, reports, financial records and books of account, medical records, prescription files, laboratory results, subcontracts, information systems and procedures, and any other documentation pertaining to medical and non-medical services rendered to Members. Upon request, through the end of the records retention period specified in Provision 19, paragraph B, above, Contractor shall furnish any record, or copy of it, to DHCS or any other entity listed in this section, at Contractor's sole expense.

If DHCS, CMS, or the DHHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit a Subcontractor at any time.

A. Facility Inspections

DHCS shall conduct unannounced validation reviews on a number of Contractor's Primary Care sites, selected at DHCS' discretion, to verify compliance of these sites with DHCS requirements.

B. Access Requirements and State's Right To Monitor

Authorized state and Federal agencies will have the right to monitor all aspects of 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. The monitoring activities may 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 shall have the right to premises access, with or without notice to Contractor. This shall include the MIS operations site or such other place where duties under the Contract are being performed.

Staff designated by authorized state agencies will have access to all security areas and Contractor will provide, and will require any and all of its subcontractors to provide, reasonable Facilities, cooperation, and assistance to state representative(s) in the performance of their duties. Access will be undertaken in such a manner as to not unduly delay the work of Contractor and/or the Subcontractors(s).

22. Confidentiality of Information

In addition to Exhibit D(F), provision 14, 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 thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by Contractor from unauthorized disclosure.

Contractor may release Medical Records in accordance with applicable law~~s~~ pertaining to the release of this type of information. Contractor is not required to report requests for Medical Records made in accordance with applicable law.

B. With respect to any identifiable information concerning a Member under this Contract that is obtained by Contractor or its subcontractors, the Contractor: (1) will not use any such information for any purpose other than carrying out the express terms of this Contract; (2) will promptly transmit to DHCS all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law; (3) will not disclose except as otherwise specifically permitted by this Contract, any such information to any party other than DHCS without DHCS' prior

written authorization specifying that the information is releasable under 42, CFR, 431.300 et seq., Welfare and Institutions Code, section 14100.2, and regulations adopted thereunder; and (4) will, at the termination of this Contract, return all such information to DHCS or maintain such information according to written procedures sent to the Contractor by DHCS for this purpose.

23. Pilot Projects

DHCS may establish pilot projects to test alternative 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.

24. Assignments

Contractor shall not assign the Contract, in whole or in part, without the prior written approval of DHCS.

25. 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 TPTL action or make a claim against the estates of deceased Members.

B. Contractor retains all 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 payer of last resort.

D. Cost Avoidance

1) If Contractor reimburses the provider on a FFS basis, Contractor shall not pay claims for services provided to a Member whose Medi-Cal eligibility record indicates third party coverage, designated

by a Other Health Coverage (OHC) code or Medicare coverage, without proof that the provider has first exhausted all sources of other payments. Contractor shall have written procedures implementing this requirement.

2) Proof of third party billing is not required prior to payment for services provided to Members with OHC codes A, M, X, Y, or Z.

E. Post-Payment Recovery

1) If Contractor reimburses the provider on a FFS basis, Contractor shall pay the provider's claim and then seek to recover the cost of the claim by billing the liable third parties for services provided to Members with OHC codes A, M, X, Y, or Z.

2) In instances where Contractor does not reimburse the provider on a FFS basis, Contractor shall pay for services provided to a Member whose eligibility record indicates third party coverage, designated by a OHC code or Medicare coverage, and then shall bill the liable third parties for the cost of actual services rendered.

3) Contractor shall also bill the liable third parties for the cost of services provided to Members who are retroactively identified by Contractor or DHCS as having OHC.

4) Contractor shall have written procedures implementing the above requirements.

F. Contractor shall initiate a Disenrollment for all Members whose eligibility record indicates OHC codes C, F, K, or P, within three state working days after Contractor becomes aware of the OHC code. Until the Member is disenrolled, Contractor shall Cost Avoid or seek Post-Payment Recovery as specified in paragraphs D. and E. above.

G. 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 Parts A. and D. 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 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. Third-Party Tort Liability

Contractor shall identify and notify DHCS' Third Party Liability Division 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 Welfare and Institutions Code section 14124.70. 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 calendar days of discovery. To assist DHCS in exercising its responsibility for such recoveries, Contractor shall meet the following requirements:

A. If DHCS requests service information and/or copies of paid invoices/claims for Covered Services to an individual Member, Contractor shall deliver the requested information within 30 calendar days of the request. Service information includes subcontractor and out-of-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) Social Security Number;

4) Date of birth;

5) Contractor name;

6) Provider name (if different from Contractor);

7) Dates of service;

8) Diagnosis code and description of illness/injury;

9) Procedure code and/or description of services rendered;

10) Amount billed by a subcontractor or out-of-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); and

14) Date of death (if applicable)

C. Contractor shall identify to DHCS' Third Party Liability Branch 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 the Third Party Liability Branch with the information contained in paragraph B., above, and shall provide the name, address and telephone number of the requesting party.

E. Information submitted to DHCS under this section shall be sent to the California Department of Health Care Services, Third Party Liability Branch, Recovery Section, MS 4720, P.O. Box 997425, Sacramento, CA 95899-7425.

Exhibit E, Attachment 2
Program Terms and Conditions

27. 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 a 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, DHCS agrees to pay Contractor for complying with paragraph A., above, as follows:

1) DHCS shall reimburse Contractor amounts paid by Contractor to third parties for services necessary to comply with paragraph A. Any third party assisting Contractor with compliance with paragraph A. above, shall comply with all applicable confidentiality requirements. Amounts paid by Contractor to any third party for assisting Contractor in complying with paragraph A., shall not exceed normal and customary charges for similar services and such charges and supporting documentation shall be subject to review by DHCS.

2) If Contractor uses existing personnel and resources to comply with paragraph A., DHCS shall reimburse Contractor as specified below. Contractor shall maintain and provide to DHCS time reports supporting the time spent by each employee as a condition of reimbursement. Reimbursement claims and supporting documentation shall be subject to review by DHCS.

a) Compensation and payroll taxes and benefits, on a prorated basis, for the employees' time devoted directly to compiling information pursuant to paragraph A.

b) Costs for copies of all documentation submitted to DHCS pursuant to paragraph A., subject to a maximum reimbursement of ten 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. Fraud and Abuse Reporting

A. For purposes of the exhibit, the following definitions apply:

Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically 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; Welfare and Institutions Code section 14043.1(a).)

Conviction or Convicted means that a judgment of conviction has been entered by a federal, state, or local court, regardless of whether an appeal from that judgment is pending (42 CFR 455.2). This definition also includes the definition of the term “convicted” in Welfare and Institutions Code section 14043.1(f).

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law (42 CFR 455.2; Welfare and Institutions Code section 14043.1(i).)

B. Contractor shall meet the requirements set forth in 42 CFR 438.608 by establishing administrative and management arrangements or procedures, as well as a mandatory compliance plan, which are designed to guard against fraud and abuse. These requirements shall be met through the following:

Exhibit E, Attachment 2
Program Terms and Conditions

1) Contractor shall establish an Anti-Fraud and Abuse Program in which there will be a compliance officer and a compliance committee for all fraud and/or abuse issues, and who shall be accountable to senior management. This program will establish policies and procedures for identifying, investigating and providing a prompt response against fraud and/or abuse in the provision of health care services under the Medi-Cal Program, and provide for the development of corrective action initiatives relating to the contract.

2) Contractor shall provide effective training and education for the compliance officer and all employees.

3) Contractor shall make provision for internal monitoring and auditing including establishing effective lines of communication between the compliance officer and employees and enforcement of standards through well-publicized disciplinary guidelines.

4) Fraud and Abuse Reporting

   Contractor shall report to the DHCS all cases of suspected fraud and/or abuse, where there is reason to believe that an incident of fraud and/or abuse has occurred, by Subcontractors, Members, providers, or employees. Contractor shall conduct, complete, and report to DHCS, the results of a preliminary investigation of the suspected fraud and/or abuse within ten working days of the date Contractor first becomes aware of, or is on notice of, such activity.

   Fraud reports submitted to DHCS must, at a minimum, include:

   a. Number of complaints of fraud and abuse submitted that warranted preliminary investigation.

   b. For each complaint which warranted a preliminary investigations, supply:

      i) name and/or SSN or CIN;

      ii) source of complaint;

      iii) type of provider (if applicable);

iv) nature of complaint;

v) approximate dollars involved; and

vi) legal and administrative disposition of the case

The report shall be submitted on a Confidential Medi-Cal Complaint Report (MC 609) that can be sent to DHCS in one of three ways:

a. Email at PIUCases@DHCS.ca.gov;

b. E-fax at (916) 440-5287; or

c. U.S. Mail at:

Department of Health Care Services
Integrated Systems of Care Division
Attention: Contract Management Unit
P.O. Box 997437
MS 4502
Sacramento, CA 95899-7437

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.

5) Tracking Suspended Providers

Contractor shall comply with 42 CFR 438.610. Additionally, Contractor is prohibited from employing, contracting or maintaining a contract with physicians or other health care providers that are excluded, suspended or terminated from participation in the Medicare or Medi-Cal/Medicaid programs. A list of suspended and ineligible providers is maintained in the Medi-Cal Provider Manual, which is updated monthly and available on line and in print at the DHCS Medi-Cal Web site (http://www.medi-cal.ca.gov) and by the DHHS, Office of Inspector General, List of Excluded Individuals and

Entities (http://oig.hhs.gov). Contractor is deemed to have knowledge of any providers on these lists. Contractor must notify the Integrated Systems of Care Division Contract Management Unit within ten state working days of removing a suspended, excluded, or terminated provider from its provider network and confirm that the provider is no longer receiving payments in connection with the Medicaid program. A removed, suspended, excluded, or terminated provider report can be sent to DHCS in one of three ways:

a. Email at PIUCases@DHCS.ca.gov;

b. E-fax at (916) 440-5287; or

c. U.S. Mail at:

Department of Health Care Services
Integrated Systems of Care Division
Attention: Contract Management Unit
P.O. Box 997437
MS 4502
Sacramento, CA 95899-7437

C. Federal False Claim Act Compliance

Contractor shall comply with 42 U.S.C., section 1396(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. Equal Opportunity Employer

Contractor will, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, state that it is an equal opportunity employer, and shall send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding, a notice to be provided by DHCS, advising the labor union or workers' representative of Contractor's commitment as an equal opportunity employer and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

Exhibit E, Attachment 2
Program Terms and Conditions

30. Discrimination Prohibitions

A. Member Discrimination Prohibition

Contractor shall not unlawfully discriminate against Members or Eligible Beneficiaries because of race, color, creed, religion, ancestry, marital status, sexual orientation, national origin, ethnic group identification, age, sex, physical or mental disability, medical condition, genetic information, gender, or gender identity, in accordance with section 1557 of the Patient Protection and Affordable Care Act of 2010, the Americans with Disabilities Act of 1990, Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972 (regarding education programs and activities, as amended); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973, as amended; the Americans with Disabilities Act of 1990, as amended, Section 11135 of the Government Code, Sections 14029.91 and 14029.92 of the Welfare and Institutions Code, rules and regulations promulgated pursuant thereto, or as otherwise provided by federal or state law or regulations. For the purpose of this Contract, discrimination includes, not limited to, the following:

1) Denying any Member any Covered Services or availability of a Facility;

2) Providing to a Member any Covered Service which is different, or is provided in a different manner or at a different time from that provided to other Members under this Contract except where medically indicated;

3) Subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service;

4) Restricting a Member in anyway in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service, treating a Member or Eligible Beneficiary differently from others in determining whether he or she satisfies any admission, Enrollment, quota, eligibility, membership or other requirement or condition which individuals must meet in order to be provided any Covered Service; or

5) The assignment of times or places for the provision of services on the basis of the sex, race, color, creed, religion, ethnic group identification, age, gender, national origin, ancestry, marital status, sexual orientation, gender identity, physical or mental disability ,

medical condition, or genetic information of the members to be served.

Contractor shall take affirmative action to ensure that Members are provided Covered Services without regard to sex, race, color, creed, religion, ethnic group identification, gender, national origin, ancestry, marital status, sexual orientation, gender identity, physical disability, mental disability, medical condition, or genetic information, except where medically indicated.

For the purposes of this section, physical handicap includes the carrying of a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genes shall include, but are not limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

B. Discrimination Related To Health Status

Contractor shall not discriminate among eligible individuals on the basis of their health status requirements or requirements for health care services during Enrollment, re-enrollment or Disenrollment. Contractor will not terminate the Enrollment of an eligible individual based on an adverse change in the Member's health.

31. Additional Federal Requirements

Contractor shall comply with all applicable federal requirements in Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities, as amended); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973, as amended; the Americans with Disabilities Act of 1990, as amended; and Section 1557 of the Patient Protection and Affordable Care Act.

32. Binding Arbitration

If Contractor uses binding arbitration to settle disputes, Contractor shall disclose this in all of Contractor's Marketing presentations and materials, new enrollee information, Member Enrollment Agreement Terms and Conditions, disclosure form, and any other informing materials, pursuant to the California Welfare and Institutions Code, section 14450, Health & Safety Code, sections 1363 and 1363.1 and the California Code of Civil Procedures section 1295.

Contractor shall comply with applicable requirements of California law relating to Disabled Veteran Business Enterprises (DVBE) commencing at section 10115 of the Public Contract Code.

33. 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.

34. Federal False Claims Act Compliance

Effective January 1, 2007, Contractor shall comply with 42USC Section 1396a(a)(68), Employee Education About False Claims Recovery, as a condition of receiving payments under this Contract. Upon request by DHCS, Contractor shall demonstrate compliance with this provision, which may include providing DHCS with copies of Contactor's applicable written policies and procedures and any relevant employee handbook excerpts.

35. State Hearings

Contractor shall provide written position statements whenever notified by DHCS that a Member has requested a state hearing. Contractor also shall designate staff to make testimony at state hearings whenever notified by DHCS of the scheduled time and place for a state hearing. Contractor responsibilities regarding state hearings are pursuant to Welfare and Institutions Code, sections 10950 through 10962, and California Code of Regulations, title 22, sections 51014.1, 51014.2, 53261 and 53452. Additional clarification of Contractor responsibilities related to state hearings shall be provided to Contractor by DHCS.

36. Federal Oversight Requirements

The Contractor is considered a contractor, and not a subrecipient for the purposes of the U.S. Office of Management and Budget Uniform Guidance (Title 2 of the Code of Federal Regulations, Part 200, and, specifically, 2 CFR 200.330).

Exhibit E, Attachment 3
Duties of the State

1. Payment For Services

DHCS shall pay the appropriate Capitation payments set forth in Exhibit B, Attachment 1 to the Contractor for each eligible Member under this Contract, and ensure that such payments are based on actuarially sound capitation rates defined in 42 CFR, Section 438.6(c). Payments will be made monthly for the duration of this Contract.

2. Medical Reviews

DHCS shall conduct medical reviews in accordance with Welfare and Institutions Code, section 14456. DHCS shall have the discretion to accept plan performance reports, audits or reviews conducted by other agencies or accrediting bodies that use standards comparable to those of DHCS. These plan performance reports, audits and reviews may be in lieu of an audit or review conducted by DHCS in order to eliminate duplication of auditing efforts.

3. Enrollment Processing

DHCS shall review applications for Enrollment submitted by Contractor and verify the eligibility of all applicants for Enrollment in Contractor's plan under this Contract. DHCS shall provide to Contractor a list of Members on a monthly basis.

4. Disenrollment Processing

DHCS shall review and process requests for Disenrollment. On an annual basis, provide in writing a schedule of the last calendar dates in each month by which requests for Disenrollment must be submitted to DHCS by Contractor to assure that Disenrollment occurs in compliance with Welfare and Institutions Code, section 14413. DHCS may revise the schedule, as necessary, to assure that the requirements of Welfare and Institutions Code, section 14413 are met. DHCS shall provide reasonable notice to Contractor of revisions to the schedule.

5. DHCS Approval Process

A. Within five working days of receipt, DHCS shall acknowledge in writing the receipt of any material sent to DHCS by Contractor pursuant to Exhibit E, Attachment 2, provision 8.

B. Within 60 calendar days of receipt, DHCS shall make all reasonable efforts to approve in writing the use of such material provided to DHCS pursuant to Exhibit E, Attachment 2, provision 8 and provide Contractor with a written explanation why its use is not approved or provide a written

estimated date of completion of DHCS' review process. If DHCS does not complete its review of submitted material within 60 calendar days of receipt or within the estimated date of completion of DHCS review, Contractor may elect to implement or use the material at Contractor's sole risk and subject to possible subsequent disapproval by DHCS. This paragraph shall not be construed to imply DHCS approval of any material that has not received written DHCS approval. This paragraph shall not apply to Subcontracts or sub-subcontracts subject to DHCS approval in accordance with Exhibit A, Attachment 6, provision 12 paragraph B.

6. DHCS Program Information

DHCS shall provide Contractor with complete and current information with respect to pertinent policies, procedures, and guidelines affecting the operation of this Contract, within 30 calendar days of receipt of Contractor's written request for information, to the extent that the information is readily available. If the requested information is not available, DHCS shall notify Contractor within 30 calendar days, in writing, of the reason for the delay and when Contractor may expect the information.

7. DHCS Catastrophic Coverage Limitation

DHCS shall limit Contractor's liability to provide or arrange and pay for care for illness of or injury to Members which results from or is greatly aggravated by, a catastrophic occurrence or disaster.

8. Risk Limitation

DHCS and Contractor agree~~s~~ there shall be no risk limitation and that Contractor will have full financial liability to provide Medically Necessary Covered Services to members as provided by the Contract and federal and state law.

9. Notice Of Termination Of Contract

DHCS shall notify Members about their health care benefits and available options upon termination or expiration of this Contract.

10. Testing of Marketing Representatives

DHCS shall test all Contractor Marketing Representatives for knowledge of the program following completion of a comprehensive training program conducted by Contractor and prior to their engaging in Marketing or Medi-Cal Managed Care information activities on behalf of Contractor. Qualified Marketing

Exhibit E, Attachment 3
Duties of the State

Representatives are those persons demonstrating adequate knowledge of the program after completing the training program conducted by Contractor and passing the Medi-Cal Marketing exam administered by DHCS.

11. Policy Letters

DHCS shall provide applicable Policy Letters to Contractor as deemed necessary.

12. Review and Evaluation

Review and evaluate, relative to provider operations and costs, all reports submitted by Contractor under the provisions of Exhibit A, Attachment 17.

Exhibit G
Business Associate Addendum

1. This Agreement has been determined to constitute a business associate relationship under the Health Insurance Portability and Accountability Act (HIPAA) and its implementing privacy and security regulations at 45 Code of Federal Regulations, Parts 160 and 164 (collectively, and as used in this Agreement)

2. The term "Agreement" as used in this document refers to and includes both this Business Associate Addendum and the contract to which this Business Associate Agreement is attached as an exhibit, if any.

3. For purposes of this Agreement, the term "Business Associate" shall have the same meaning as set forth in 45 CFR section 160.103.

4. The Department of Health Care Services (DHCS) intends that Business Associate may create, receive, maintain, transmit or aggregate certain information pursuant to the terms of this Agreement, some of which information may constitute Protected Health Information (PHI) and/or confidential information protected by Federal and/or state laws.

4.1 As used in this Agreement and unless otherwise stated, the term "PHI" refers to and includes both "PHI" as defined at 45 CFR section 160.103 and Personal Information (PI) as defined in the Information Practices Act at California Civil Code section 1798.3(a). PHI includes information in any form, including paper, oral, and electronic.

4.2 As used in this Agreement, the term "confidential information" refers to information not otherwise defined as PHI in Section 4.1 of this Agreement, but to which state and/or federal privacy and/or security protections apply.

5. Contractor (however named elsewhere in this Agreement) is the Business Associate of DHCS acting on DHCS's behalf and provides services or arranges, performs or assists in the performance of functions or activities on behalf of DHCS, and may create, receive, maintain, transmit, aggregate, use or disclose PHI (collectively, "use or disclose PHI") in order to fulfill Business Associate's obligations under this Agreement. DHCS and Business Associate are each a party to this Agreement and are collectively referred to as the "parties."

6. The terms used in this Agreement, but not otherwise defined, shall have the same meanings as those terms in HIPAA. Any reference to statutory or regulatory language shall be to such language as in effect or as amended.

7. **Permitted Uses and Disclosures of PHI by Business Associate**. Except as otherwise indicated in this Agreement, Business Associate may use or disclose PHI only to perform functions, activities or services specified in this Agreement on behalf of DHCS, provided that such use or disclosure would not violate HIPAA if done by DHCS.

7.1 **Specific Use and Disclosure Provisions**. Except as otherwise indicated in this Agreement, Business Associate may use and disclose PHI if necessary for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate. Business Associate may disclose PHI for this purpose if the disclosure is required by law, or the Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware that the confidentiality of the information has been breached.

8. **Compliance with Other Applicable Law**

8.1 To the extent that other state and/or federal laws provide additional, stricter and/or more protective (collectively, more protective) privacy and/or security protections to PHI or other confidential information covered under this Agreement beyond those provided through HIPAA, Business Associate agrees:

8.1.1 To comply with the more protective of the privacy and security standards set forth in applicable state or federal laws to the extent such standards provide a greater degree of protection and security than HIPAA or are otherwise more favorable to the individuals whose information is concerned; and

8.1.2 To treat any violation of such additional and/or more protective standards as a breach or security incident, as appropriate, pursuant to Section 18. of this Agreement.

8.2 Examples of laws that provide additional and/or stricter privacy protections to certain types of PHI and/or confidential information, as defined in Section 4. of this Agreement, include, but are not limited to the Information Practices Act, California Civil Code sections 1798-1798.78, Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, Welfare and Institutions Code section 5328, and California Health and Safety Code section 11845.5.

8.3 If Business Associate is a Qualified Service Organization (QSO) as defined in 42 CFR section 2.11, Business Associate agrees to be bound by and comply with subdivisions (2)(i) and (2)(ii) under the definition of QSO in 42 CFR section 2.11.

9. Additional Responsibilities of Business Associate

9.1 Nondisclosure. Business Associate shall not use or disclose PHI or other confidential information other than as permitted or required by this Agreement or as required by law.

9.2 Safeguards and Security.

9.2.1 Business Associate shall use safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI and other confidential data and comply, where applicable, with subpart C of 45 CFR Part 164 with respect to electronic protected health information, to prevent use or disclosure of the information other than as provided for by this Agreement. Such safeguards shall be, at a minimum, at Federal Information Processing Standards (FIPS) Publication 199 protection levels.

9.2.2 Business Associate shall, at a minimum, utilize an industry-recognized security framework when selecting and implementing its security controls, and shall maintain continuous compliance with its selected framework as it may be updated from time to time. Examples of industry-recognized security frameworks include but are not limited to

9.2.2.1 NIST SP 800-53 – National Institute of Standards and Technology Special Publication 800-53

9.2.2.2 FedRAMP – Federal Risk and Authorization Management Program

9.2.2.3 PCI – PCI Security Standards Council

9.2.2.4 ISO/ESC 27002 – International Organization for Standardization / International Electrotechnical Commission standard 27002

9.2.2.5 IRS PUB 1075 – Internal Revenue Service Publication 1075

9.2.2.6 HITRUST CSF – HITRUST Common Security Framework

9.2.3 Business Associate shall maintain, at a minimum, industry standards for transmission and storage of PHI and other confidential information.

9.2.4 Business Associate shall apply security patches and upgrades, and keep virus software up-to-date, on all systems on which PHI and other confidential information may be used.

9.2.5 Business Associate shall ensure that all members of its workforce with access to PHI and/or other confidential information sign a confidentiality statement prior to access to such data. The statement must be renewed annually.

9.2.6 Business Associate shall identify the security official who is responsible for the development and implementation of the policies and procedures required by 45 CFR Part 164, Subpart C.

9.3 Business Associate's Agent. Business Associate shall ensure that any agents, subcontractors, subawardees, vendors or others (collectively, "agents") that use or disclose PHI and/or confidential information on behalf of Business Associate agree to the same restrictions and conditions that apply to Business Associate with respect to such PHI and/or confidential information.

10. **Mitigation of Harmful Effects**. Business Associate shall mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI and other confidential information in violation of the requirements of this Agreement.

11. **Access to PHI.** Business Associate shall make PHI available in accordance with 45 CFR section 164.524.

12. **Amendment of PHI.** Business Associate shall make PHI available for amendment and incorporate any amendments to protected health information in accordance with 45 CFR section 164.526.

13. **Accounting for Disclosures.** Business Associate shall make available the information required to provide an accounting of disclosures in accordance with 45 CFR section 164.528.

14. **Compliance with DHCS Obligations.** To the extent Business Associate is to carry out an obligation of DHCS under 45 CFR Part 164, Subpart E, comply with the requirements of the subpart that apply to DHCS in the performance of such obligation.

15. **Access to Practices, Books and Records.** Business Associate shall make its internal practices, books, and records relating to the use and disclosure of PHI on behalf of DHCS available to DHCS upon reasonable request, and to the federal Secretary of Health and Human Services for purposes of determining DHCS' compliance with 45 CFR Part 164, Subpart E.

16. **Return or Destroy PHI on Termination; Survival.** At termination of this Agreement, if feasible, Business Associate shall return or destroy all PHI and other confidential information received from, or created or received by Business Associate on behalf of, DHCS that Business Associate still maintains in any form and retain no copies of such information. If return or destruction is not feasible, Business Associate shall notify DHCS of the conditions that make the return or destruction infeasible, and DHCS and Business Associate shall determine the terms and conditions under which Business Associate may retain the PHI. If such return or destruction is not feasible, Business Associate shall extend the protections of this Agreement to the information and limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

17. **Special Provision for SSA Data.** If Business Associate receives data from or on behalf of DHCS that was verified by or provided by the Social Security Administration (SSA data) and is subject to an agreement between DHCS and SSA, Business Associate shall provide, upon request by DHCS, a list of all employees and agents and employees who have access to such data, including employees and agents of its agents, to DHCS.

18. **Breaches and Security Incidents.** Business Associate shall implement reasonable systems for the discovery and prompt reporting of any breach or security incident, and take the following steps:

18.1 Notice to DHCS.

18.1.1 Business Associate shall notify DHCS **immediately** upon the discovery of a suspected breach or security incident that involves SSA data. This notification will be provided by email upon discovery of the breach. If Business Associate is unable to provide notification by email, then Business Associate shall provide notice by telephone to DHCS.

18.1.2 Business Associate shall notify DHCS **within 24 hours by email** (or by telephone if Business Associate is unable to email DHCS) of the discovery of:

18.1.2.1 Unsecured PHI if the PHI is reasonably believed to have been accessed or acquired by an unauthorized person;

18.1.2.2 Any suspected security incident which risks unauthorized access to PHI and/or other confidential information;

18.1.2.3 Any intrusion or unauthorized access, use or disclosure of PHI in violation of this Agreement; or

18.1.2.4 Potential loss of confidential data affecting this Agreement.

18.1.3 Notice shall be provided to the DHCS Program Contract Manager (as applicable), the DHCS Privacy Office, and the DHCS Information Security Office (collectively, "DHCS Contacts") using the DHCS Contact Information at Section 18.6. below.

Notice shall be made using the current DHCS "Privacy Incident Reporting Form" ("PIR Form"; the initial notice of a security incident or breach that is submitted is referred to as an "Initial PIR Form") and shall include all information known at the time the incident is reported. The form is available online at 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, Business Associate shall take:

18.1.3.1 Prompt action to mitigate any risks or damages involved with the security incident or breach; and

18.1.3.2 Any action pertaining to such unauthorized disclosure required by applicable Federal and State law.

18.2 Investigation. Business Associate shall immediately investigate such security incident or confidential breach.

18.3 Complete Report. To provide a complete report of the investigation to the DHCS contacts within ten (10) working days of the discovery of the security incident or breach. This "Final PIR" must include any applicable additional information not included in the Initial Form. The Final PIR Form shall include an assessment of all known factors relevant to a determination of whether a breach occurred under HIPAA and other applicable federal and state laws. The report shall also include a full, detailed corrective action plan, including its implementation date and information on mitigation measures taken to halt and/or contain the improper use or disclosure. If DHCS requests information in addition to that requested through the PIR form, Business Associate shall make reasonable efforts to provide DHCS with such information. A "Supplemental PIR" may be used to submit revised or additional information after the Final PIR is submitted. DHCS will review and approve or disapprove Business Associate's determination of whether a breach occurred, whether the security incident or breach is

reportable to the appropriate entities, if individual notifications are required, and Business Associate's corrective action plan.

18.3.1 If Business Associate does not complete a Final PIR within the ten (10) working day timeframe, Business Associate shall request approval from DHCS within the ten (10) working day timeframe of a new submission timeframe for the Final PIR.

18.4 Notification of Individuals. If the cause of a breach is attributable to Business Associate or its agents, Business Associate shall notify individuals accordingly and shall pay all costs of such notifications, as well as all costs associated with the breach. The notifications shall comply with applicable federal and state law. DHCS shall approve the time, manner and content of any such notifications and their review and approval must be obtained before the notifications are made.

18.5 Responsibility for Reporting of Breaches to Entities Other than DHCS. If the cause of a breach of PHI is attributable to Business Associate or its subcontractors, Business Associate is responsible for all required reporting of the breach as required by applicable federal and state law.

18.6 DHCS Contact Information. To direct communications to the above referenced DHCS staff, the Contractor shall initiate contact as indicated here. DHCS reserves the right to make changes to the contact information below by giving written notice to Business Associate. These changes shall not require an amendment to this Agreement.

DHCS Program Contract Manager	**DHCS Privacy Office**	**DHCS Information Security Office**
See the Scope of Work exhibit for Program Contract Manager information. If this Business Associate Agreement is not attached as an exhibit to a contract, contact the DHCS signatory to this Agreement.	Privacy Office c/o: Office of HIPAA Compliance Department of Health Care Services P.O. Box 997413, MS 4722 Sacramento, CA 95899-7413 Email: incidents@dhcs.ca.gov Telephone: (916) 445-4646	Information Security Office DHCS Information Security Office P.O. Box 997413, MS 6400 Sacramento, CA 95899-7413 Email: incidents@dhcs.ca.gov

19. Responsibility of DHCS. DHCS agrees to not request the Business Associate to use or disclose PHI in any manner that would not be permissible under HIPAA and/or other applicable federal and/or state law.

20. Audits, Inspection and Enforcement

20.1 From time to time, DHCS may inspect the facilities, systems, books and records of Business Associate to monitor compliance with this Agreement. Business Associate shall promptly remedy any violation of this Agreement and shall certify the same to the DHCS Privacy Officer in writing. Whether or how DHCS exercises this provision shall not in any respect relieve Business Associate of its responsibility to comply with this Agreement.

20.2 If Business Associate is the subject of an audit, compliance review, investigation or any proceeding that is related to the performance of its obligations pursuant to this Agreement, or is the subject of any judicial or administrative proceeding alleging a violation of HIPAA, Business Associate shall promptly notify DHCS unless it is legally prohibited from doing so.

21. Termination

21.1 Termination for Cause. Upon DHCS' knowledge of a violation of this Agreement by Business Associate, DHCS may in its discretion:

21.1.1 Provide an opportunity for Business Associate to cure the violation and terminate this Agreement if Business Associate does not do so within the time specified by DHCS; or

21.1.2 Terminate this Agreement if Business Associate has violated a material term of this Agreement.

21.2 Judicial or Administrative Proceedings. DHCS may terminate this Agreement if Business Associate is found to have violated HIPAA, or stipulates or consents to any such conclusion, in any judicial or administrative proceeding.

22. Miscellaneous Provisions

22.1 Disclaimer. DHCS makes no warranty or representation that compliance by Business Associate with this Agreement will satisfy Business Associate's business needs or compliance obligations. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI and other confidential information.

22.2. Amendment.

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

22.2.2 Failure by Business Associate to take necessary actions required by amendments to this Agreement under Section 22.2.1 shall constitute a material violation of this Agreement.

22.3 Assistance in Litigation or Administrative Proceedings. Business Associate shall make itself and its employees and agents available to DHCS at no cost to DHCS to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against DHCS, its directors, officers and/or employees based upon claimed violation of HIPAA, which involve inactions or actions by the Business Associate.

22.4 No Third-Party Beneficiaries. Nothing in this Agreement is intended to or shall confer, upon any third person any rights or remedies whatsoever.

22.5 Interpretation. The terms and conditions in this Agreement shall be interpreted as broadly as necessary to implement and comply with HIPAA and other applicable laws.

22.6 No Waiver of Obligations. No change, waiver or discharge of any liability or obligation hereunder on any one or more occasions shall be deemed a waiver of performance of any continuing or other obligation, or shall prohibit enforcement of any obligation, on any other occasion.