1. **Service Overview**

The Contractor, operating as an organized health care delivery system, agrees to provide the Department of Health Care Services (DHCS) with Administrative services, as described in Exhibit A, Attachment I, and Comprehensive Care Management services, as described in Exhibit A, Attachment II, under the Medi-Cal Home- and Community-Based Alternatives (HCBA) Waiver authorized by Section 1915(c) of Title XIX of the Social Security Act; and described herein. Waiver programs authorized by Section 1915(c) manage the provision of home and community-based services to eligible Medi-Cal members who would otherwise receive care in an intermediate care facility, a skilled nursing facility, a subacute facility, or an acute care hospital. The goal of the HCBA Waiver program is to ensure the safe transition of eligible Medi-Cal members from facilities to the community; or, to offer home-based services to members currently residing in the community who are at risk of being placed in a long-term care facility within the next thirty days. As with all 1915(c) Waiver programs, the total aggregate cost for members’ combined Waiver and state plan services received in the community must not exceed 100% of the total aggregate cost of services that would be provided to the same population in an institution, as demonstrated in Appendix J of the Waiver, available at: [http://www.dhcs.ca.gov/services/ltc/Pages/Home-and-Community-Based-(HCB)-Alternatives-Waiver.aspx](http://www.dhcs.ca.gov/services/ltc/Pages/Home-and-Community-Based-(HCB)-Alternatives-Waiver.aspx). Home- and community-based services (HCBS) and supports include, but are not limited to private duty nursing and case management services.

2. **Service Location**

The HCBA Waiver services shall be provided to HCBA Waiver participants residing in [County(ies)], {add the following language if applicable} [as well as in the zip codes listed in Exhibit A, Attachment III – Service Area Zip Codes].

3. **Service Hours**

The Contractor’s administrative services must be available during the normal business hours of 8:00 a.m. to 5:00 p.m., PST, Monday through Friday. Authorized HCB services and supports shall be made available to HCBA Waiver participants twenty-four (24) hours per day, seven (7) days per week, as approved.

4. **Project Representative**

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

<table>
<thead>
<tr>
<th>Department of Health Care Services</th>
<th>[Waiver Agency]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contract Manager:</td>
<td>Contract Manager:</td>
</tr>
<tr>
<td>Telephone:</td>
<td>Telephone:</td>
</tr>
<tr>
<td>Email:</td>
<td>Email:</td>
</tr>
</tbody>
</table>
B. Direct all inquiries to:

<table>
<thead>
<tr>
<th>Department of Health Care Services</th>
<th>[Waiver Agency]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contract Management Unit</td>
<td>Attention: [WA Contract Manager]</td>
</tr>
<tr>
<td>Attention: [Unit Manager]</td>
<td>[Waiver Agency]</td>
</tr>
<tr>
<td>Mail Station Code 4502</td>
<td>5400 Atlantis Court</td>
</tr>
<tr>
<td>1515 K Street</td>
<td>Moorpark, CA 93021</td>
</tr>
<tr>
<td>P.O. Box 997437</td>
<td>Telephone: (805) 517-1620</td>
</tr>
<tr>
<td>Sacramento, CA 95899-7437</td>
<td>Email:</td>
</tr>
<tr>
<td>Telephone:</td>
<td></td>
</tr>
<tr>
<td>Email:</td>
<td></td>
</tr>
</tbody>
</table>

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

5. 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.
1. HCBA Waiver Program Administrative Responsibilities

   A. Verification of HCBA Waiver Participant Eligibility

      1) Contractor shall only provide HCBA Waiver services to individuals
determined to be eligible for the HCBA Waiver program. To be eligible for
the Waiver, individuals must meet all of the following criteria:

         a. Individuals must be enrolled in, or be eligible for, Medi-Cal, with or
            without a share of cost, as defined in the HCBA Waiver.

         b. Individuals who, but for the provision of such services, would require
            placement in a medical care facility, for at least 90 days, at one of the
            three levels of care (LOC) identified below and as defined in 42 CFR
            §440. Applicants must continue to meet one of the three LOC to remain
            enrolled in the Waiver.

            i. **Acute LOC** – Individuals at the acute level of care are characterized
               by their need for continuously available nursing and medical care, as
               is available at an acute care facility, which includes the need for daily
               physician visits. Individuals who meet the acute level of care require
               the services available in an acute hospital setting for 90 consecutive
days or greater pursuant to CCR, Title 22, §51173.1 and meet the
               criteria as described in CCR, Title 22, §51344 (a) and (b).

            ii. **Subacute LOC** – Individuals at the subacute level of care require
                more intensive licensed skilled nursing care than is provided to the
                majority of patients in a skilled nursing facility, but do not require
                continuous availability of nursing and medical care. These
                individuals must require NF Subacute Care services, pursuant to
                Title 22, CCR, §51124.5; or NF Pediatric Subacute Care services,
pursuant to Title 22, CCR, §51124.6

            iii. **Nursing Facility LOC (NF-A, NF-B)** – Individuals at the nursing
                 facility LOC require care that is characterized by scheduled and
                 predictable nursing needs. Pursuant to W&I Code, §14059.5, these
                 individuals require protective and supportive care, without the need
                 for continuous, licensed nursing, for 90 consecutive days or greater in
                 an inpatient NF providing the following types of care:
Exhibit A – Attachment I
Waiver Administrative Services

(a) **NF Level A** – Intermediate Care services pursuant to Title 22, CCR, §51120 and 51334.

(b) **NF Level B** – Skilled Nursing Facility services pursuant to Title 22, CCR §511224 and 51335.

c. Individuals who require the provision of at least one Waiver service, as documented in the Person-Centered Plan of Treatment (POT), at least once a month; or, if the need for services is less than monthly, the participant must require regular monthly monitoring, as documented in the POT.

2) When a Waiver applicant meets the Waiver eligibility criteria, but special rules need to be applied to determine a Waiver Applicant’s Medi-Cal eligibility (because of their pending enrollment in the HCBA Waiver), the Contractor shall send a letter to the applicant’s county Medi-Cal office to notify the County that the applicant meets the medical criteria for the Waiver. When applicable, the letter must identify when spousal impoverishment rules (if the applicant is over 18 and married) or institutional deeming rules (if the applicant is a child under 18) are to be used to determine the applicant’s Medi-Cal status. DHCS will supply a letter template for this purpose.

B. Participant Waiver Enrollment

1) The Contractor shall be responsible for participant enrollment in the HCBA Waiver in the designated geographical area and as directed by DHCS. This responsibility includes processing Waiver applications received directly from or on behalf of applicants. Applications shall be submitted to the Contractor by mail, FAX, electronically, or in-person.

2) Contractor must develop and maintain an intake process using the MedCompass Case Management Database to accept, log, track, process, and store all enrollment-related forms and transactions. Access to the MedCompass Case Management Database is subject to the terms and conditions detailed in Exhibit G, the HIPAA Business Associate Addendum.

3) In addition, the Contractor is responsible for administering the following participant enrollment responsibilities:
Exhibit A – Attachment I
Waiver Administrative Services

a. Conducting Waiver intake activities, including accepting applications from individuals applying to enroll in the Waiver.

b. When necessary, referring individuals to the County Medi-Cal office for the determination of Medi-Cal eligibility and/or disability.

c. Ensuring enrollment applications are recorded in MedCompass within three business days of receipt.

d. Ensuring each application is screened by a Registered Nurse (RN) to determine if the applicant meets the minimum HCBA Waiver LOC eligibility requirements.

e. Working in conjunction with DHCS to ensure:

   i. HCBA Waiver enrollment is limited to the maximum number of Waiver slots that can be authorized at any point of time within each Waiver year. DHCS will inform the Contractor when the Waiver is nearing the maximum number of Waiver slots, and will provide instructions on the waitlist enrollment process, see sub-provision C. “Waitlist”, below.

   ii. Eligible Waiver participants are only enrolled in a single 1915(c) Waiver program at a time.

   iii. Waiver services are not furnished to individuals who are current in-patients of a facility, in accordance with 42 CFR §441.301(b)(1)(ii), except for Waiver Personal Care Services (WPCS) and Transitional Care Management that may be provided, according to the specifications of the HCBA Waiver, while the participant is admitted to a health care facility as defined in Health & Safety Code section 1250.

   iv. Medi-Cal members who are dually eligible for Medicare and Medi-Cal are not enrolled in Cal MediConnect (dually eligible Medi-Cal members cannot enroll or continue enrollment in the HCBA Waiver if they are enrolled in Cal MediConnect).

f. Ensuring the Care Management Team (CMT) schedules a face-to-face visit with the applicant within 60 days of receipt of a qualified application and/or notification of an available waiver slot to assess the individual for enrollment, provide the applicant, and/or legal representative/legally responsible adult,
with information on the HCBA Waiver, and to obtain the information necessary to complete a case report.

g. Ensuring that a case report is completed and uploaded in MedCompass within one week after the intake onsite visit for a DHCS Medical Consultant to determine if the applicant is eligible for waiver enrollment.

h. DHCS will notify the Contractor when an applicant is approved for enrollment, and the Contractor shall notify the applicant by phone and by mailing a written Informing Notice, to inform the applicant that he or she:

i. Has met the criteria for enrollment into the Waiver,

ii. Must work with his or her CMT to identify direct waiver service provider(s), and

iii. Has 90 days to submit a physician-signed POT from the date of the Informing Notice.

i. If DHCS determines an applicant is not eligible for enrollment into the Waiver, DHCS will notify the Contractor that the applicant is not eligible for the Waiver, and DHCS will issue a Notice of Action (NOA) to the applicant.

j. Contractor must provide DHCS with a primary care physician-signed POT, within 90 days from the date of the Informing Notice, that meets the requirements outlined in Appendix D of the HCBA Waiver, available at: [http://www.dhcs.ca.gov/services/ltc/Documents/HCB_Alternatives_Waiver_Draft_4_28_17.pdf](http://www.dhcs.ca.gov/services/ltc/Documents/HCB_Alternatives_Waiver_Draft_4_28_17.pdf).

k. Ensuring the following HCBA Waiver enrollment composition:

<table>
<thead>
<tr>
<th>Percent of Waiver Enrollment</th>
<th>Population Seeking Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>At least 60%</td>
<td>Individuals living in an institution, or aging out of EPSDT</td>
</tr>
<tr>
<td>No more than 40%</td>
<td>Individuals residing in the community at risk of institutionalization</td>
</tr>
</tbody>
</table>
Exhibit A – Attachment I
Waiver Administrative Services

I. Ensuring reserve capacity enrollment prioritization for individuals residing in an institutional setting for at least 90 days, or individuals transitioning from Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), or similar programs. To qualify for reserve capacity enrollment, an individual must meet one of the following criteria:

i. The individual has been in an institutional setting for at least 90 days, and will remain there if not for the provision of HCBA Waiver services in the home or community setting of his or her choice; or

ii. The individual must be a current Medi-Cal member who will turn 21 years of age during the current Waiver year and has been receiving, or has been authorized to receive, private duty nursing services for at least six months prior to his or her 21st birthday, through programs such as EPSDT, California Children’s Services (CCS), and the Pediatric Palliative Care (PPC) Waiver; and must be medically eligible for placement into the HCBA Waiver.

m. If the applicant is not eligible for reserve capacity enrollment prioritization and a Waiver slot is not available, the Contractor will notify DHCS of the need to place the applicant on the Waitlist, and will send a letter to notify the applicant that his or her name has been placed on a waitlist.

C. Waitlist

1) DHCS will maintain the master HCBA Waiver Waitlist.

2) DHCS will notify the Contractor when a Waiver slot becomes available for any of the applicants on the Waitlist within the Contractor’s geographic service area.

3) Upon notification of an available Waiver slot from DHCS, if the face-to-face visit has not yet occurred, the Contractor will schedule an intake face-to-face meeting (within 60 days of the notification of an available Waiver slot) to assess the individual for enrollment, provide the applicant, and/or legal representative/legally responsible adult, with information on the HCBA Waiver, and to obtain the information necessary to complete a case report within one week after the visit.

4) The Contractor submits the case report and supporting information to DHCS, and a DHCS Medical Consultant reviews the case report to
Exhibit A – Attachment I
Waiver Administrative Services

determine if the applicant is eligible for waiver enrollment. If approved for enrollment, DHCS will notify the Contractor, and the Contractor shall notify the applicant by phone and by mailing an Informing Notice. The Informing Notice informs the applicant that he or she:

a. Has met the criteria for enrollment into the Waiver,
b. Must work with their CMT to identify direct waiver service provider(s), and
c. Has 90 days to submit a physician-signed POT.

5) Contractor must provide DHCS with a primary care physician-signed POT that meets the requirements outlined in Appendix D of the HCBA Waiver, available at: [http://www.dhcs.ca.gov/services/ltc/Pages/Home-and-Community-Based-(HCB)-Alternatives-Waiver.aspx](http://www.dhcs.ca.gov/services/ltc/Pages/Home-and-Community-Based-(HCB)-Alternatives-Waiver.aspx).

If the POT is more than six months old at the time the Contractor is notified that a waiver slot is available, the Contractor must work with the applicant, his or her legal representative, and the applicant’s primary care physician, to reassess the applicant and update the applicant’s POT, as necessary, to ensure it continues to meet his or her need(s).

D. Comprehensive Care Management

1) Contractor shall ensure Comprehensive Care Management is only provided to HCBA Waiver participants by a qualified CMT comprised of a Registered Nurse and Social Worker with at least a Master’s degree, who are either directly employed or sub-contracted by the Contractor.

2) Comprehensive Care Management is intensive, ongoing case management and is described in detail in Exhibit A, Attachment II – Comprehensive Care Management, of this Contract.

3) Contractor will ensure through regular monitoring and oversight that the CMT coordinates all Waiver services with service providers included in the participants’ POT, and performs all services required under the Comprehensive Care Management Services benefit as described in detail in Exhibit A, Attachment II, Comprehensive Care Management, of this Contract.

E. Utilization Management

HCBA Waiver service providers submit service Authorization Requests to the
Contractor for authorization of all HCB Alternatives Waiver services (except the WPCS benefit, which is paid through a separate payroll system, see Exhibit B, Provision 2)) prior to providing the services.

1) Contractor shall review service authorization requests for medical necessity to ensure services are authorized in accordance with Waiver requirements and the participant’s POT.

Medical necessity is defined as set forth in Welfare and Institutions Code 14059.5, as follows: A service is “medically necessary” or of a “medical necessity” when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.

2) When the Contractor does not authorize a service authorization request because the service(s) is not medically necessary, Contractor must issue a NOA to inform the participant of the denial. See Provision 4.H. for more information on NOA requirements.

3) Contractor must monitor service utilization to ensure the amount of services is within the levels authorized in the participant’s POT by developing, implementing, and maintaining review procedures to identify instances when participants are not receiving services as authorized in the POT, or when the amount of services being utilized is substantially less than the amount authorized, so that potential problems with participant service access can be identified and resolved.

F. Provider Authorization Requests & Service Reimbursement

1) Contractor must process undisputed service authorization requests within 30 days of submission from the Waiver service provider.

2) If the Contractor is submitting to the Medi-Cal Fiscal Intermediary (FI) the invoices for provided Waiver services on behalf of the service providers, the Contractor must reimburse the Waiver service providers no less than the Medi-Cal Fee-For-Service reimbursement rate specified within the Waiver or the Department’s fee schedule within 45 calendar days if the service provider submits an undisputed claim for providing authorized Waiver services.

3) This provision is intentionally left.

G. Ensuring Participant Access to Qualified Service Providers
Exhibit A – Attachment I
Waiver Administrative Services

1) Contractor shall have a formal Waiver service provider sub-contracting process to engage qualified providers for all Waiver services and to monitor the provision of services by the contracted providers. Sub-contract agreements must be in writing. Sub-contracting agreements must conform to and may not supersede or modify any requirement within the HCBA Waiver, this Contract, federal and state regulations, or the HCBA Program Manual.

2) Contractor shall ensure all HCBA Waiver service providers are enrolled as Medi-Cal Providers, and shall submit the legal names of prospective waiver providers to DHCS to check against the Temporary Suspension list prior to execution of a sub-contract.

3) Contractor shall maintain an adequate provider network made up of provider types identified in the HCBA Waiver to ensure Waiver participants receive all services necessary to remain safely in their home.

4) Contractor shall provide participants and DHCS with an up-to-date list of available qualified providers within the provider network each quarter.

5) Contractor shall ensure access to qualified HCBS providers by entering into sub-contracts with qualified service providers, and/or purchasing goods and/or services from qualified vendors. When there are no qualified service providers available to provide Waiver services, and DHCS has approved the Contractor’s request to provide direct services, the Contractor may hire staff to ensure participant access to qualified service providers.

6) Contractor shall ensure all existing HCBA Waiver service providers within the contracted service area are given the option to enter into a network provider sub-contract with the Contractor, to continue to provide direct HCBA Waiver services to participants under the Waiver.

7) Contractor shall collect current copies of licenses and accreditations to ensure all licensed providers meet state licensure requirements and the Standards of Participation (SOP) as described in Appendix C of the HCBA Waiver.

8) Contractor shall ensure the continuous availability and accessibility of all services included in each participant’s POT by sub-contracting with qualified service providers, such as: licensed home health agencies,
durable medical equipment companies, individual nurse providers, licensed clinical social workers, marriage and family therapists, personal care agencies, non-profit organizations, professional corporations, individual personal care providers, and certain community residential facilities; and/or a separate division of the provider's organization pending DHCS approval.

9) Contractor shall implement strategies to recruit, retain, and promote a diverse staff at all levels of the organization and leadership that is representative of the demographic characteristics of the service area.

10) Contractor shall ensure participants receive effective and respectful care provided in a manner that is compatible with their cultural health beliefs, practices, and preferred language.

11) Contractor shall document that non-licensed providers have received onboarding and training from the California Department of Social Services, or the Department of Rehabilitation; and, that non-licensed providers attend annual training from the Contractor to ensure they have the necessary skills and abilities to provide services as described in the Waiver participant’s POT.

12) Contractor shall document all training provided to unlicensed and licensed providers as outlined in provision 6.G. of this contract, and on the provision of care by provider type as required under the Waiver, refer to Appendix C of the Waiver for more information about the requirements for provider-specific training.

H. Contractor as the Only Qualified Provider

1) In areas where the Contractor is the only willing and qualified provider, the Contractor shall be responsible for providing POT development and Waiver services directly to the participant. In such instances:

   a. Contractor shall develop Policies & Procedures that describe the specific responsibilities of the Contractor, CMT, and the Waiver service providers.

   b. Contractor shall sign a formal agreement with DHCS verifying the organization’s willingness to ensure that there is a clear separation between lines of supervision, the CMT’s provision of Comprehensive
Exhibit A – Attachment I
Waiver Administrative Services

Care Management, and the staff who provide Waiver services.

c. Ensure the CMT and staff providing Waiver services sign agreements acknowledging their understanding of, and willingness to, comply with mandated separation of Comprehensive Care Management and Waiver service functions.

d. Contractor shall submit signed agreements to DHCS and receive DHCS’ approval prior to staff having any contact with newly enrolled Waiver participants.

2) Contractor’s CMTs will provide the participant with a full disclosure form to review and sign prior to his or her enrollment in the Waiver in areas where the Contractor is the only willing and qualified direct service provider. The form will be provided by DHCS and will include the following:

a. Full disclosure and assurances that participants are supported in exercising their right of free choice in providers;

b. Describing the individual dispute resolution process;

c. Full disclosure that the Contractor is the only willing and qualified provider available to provide case management and Waiver services in the participant’s geographical service area;

d. Assurance that the Contractor will separate Comprehensive Case Management and the provision of direct Waiver services (different staff with different lines of supervision);

e. Assurance that the Contractor providing Comprehensive Care Management and Waiver services does so only with the approval of DHCS; and

f. That DHCS will provide direct oversight and periodic evaluation of the effectiveness and appropriateness of established safeguards.

I. DHCS Final Review and Approval of Waiver Enrollment

1) The Contractor shall notify DHCS that a case file, with a signed POT and all necessary documentation supporting the service needs assessment and medical necessity of services, is ready for DHCS review.

2) Contractor must not authorize services until DHCS has approved the applicant’s enrollment into the waiver. Contractor shall maintain all
Exhibit A – Attachment I
Waiver Administrative Services

documentation to support service needs assessments in the participant’s case file in MedCompass.

3) DHCS will review the documentation supporting the service needs assessment and medical necessity and will provide the final determination for HCBA Waiver enrollment.

DHCS will then notify Contractor that waiver enrollment has been approved. If DHCS determines that enrollment cannot be authorized, then DHCS will send a NOA to the applicant and notify the Contractor.

J. Quality Assurance and Performance Improvement Activities

1) Contractor shall implement quality assurance and performance improvement activities in accordance with the Performance Measures in the Waiver and this Contract. 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 Waiver 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 or negligence committed by a subcontractor.

2) Contractor shall implement and maintain a written description of a quality assurance and performance improvement plan that shall include, but is not limited to, the following:

a. Organizational commitment to the delivery of quality health care services as evidenced by goals and objectives that are periodically evaluated and updated.

b. Description of the processes and procedures designed to ensure all medically necessary Waiver services are available and accessible to all Waiver participants, and that all Waiver services are provided in a culturally and linguistically appropriate manner.

c. Description of the mechanisms used to continuously review, evaluate, and improve the quality of Waiver services, which may include, but is not limited to, customer satisfaction surveys, aggregated data trend analysis, internal audits, etc.
3) Contractor shall ensure ongoing oversight of network providers by monitoring provider performance on an ongoing basis, identify and report deficiencies, and work closely with service providers to develop a plan of corrective action to remediate deficiencies. Contractor shall cooperate with DHCS to perform discovery and remediation activities for the Waiver and develop mechanisms for overall systems improvements. These activities may result in additional quality assurance measures to ensure compliance with federal, state, and Waiver requirements, as determined by DHCS.

2. HCBA Waiver Services

A. In addition to assessing clinical need(s) and coordinating medically necessary services and supports, Comprehensive Care Management includes the coordination and utilization of existing community resources to enable Waiver participants to transition from a health care facility to the community or to continue living at home in lieu of facility placement. The HCBA Waiver Comprehensive Care Management service includes participant assessment, care planning, service arrangement, and Waiver participant and service provider monitoring. Refer to Exhibit A, Attachment II for more information on the Contractor’s obligations for Comprehensive Care Management under this Contract.

B. Contractor shall ensure the provision of all of the HCBA Waiver services included below, as medically necessary for each individual Waiver participant, and as defined in Appendix C of the HCBA Waiver:

1) Habilitation
2) Home Respite
3) Community Transition Services
4) Continuing Nursing and Supportive Services
5) Environmental Accessibility Adaptation
6) Facility Respite
7) Family/Caregiver Training
8) Medical Equipment Operating Expenses
9) Personal Emergency Response System (PERS) Installation and Testing
10) PERS Monthly Service

11) Private Duty Nursing – Including home health aide and shared services

12) Waiver Personal Care Services – Contractor shall be responsible for determining the ongoing medical necessity of WPCS for Waiver participants; however, unlike all of the other direct waiver services, the Contractor will not be responsible for the authentication or flow of provider payments. See Exhibit B, Provision 1. for more information on WPCS provider payments.

3. Contractor-Enforced Waiver Participant Rights

A. Person-Centered Planning

1) Contractor shall ensure Waiver participants are given the opportunity to lead the person-centered planning process when desired and possible; the individuals’ legal representatives should have a participatory role, if applicable. Contractor must ensure the person-centered planning process:

a. Includes people the participant chooses to support him or her in the person-centered planning process.

b. Provides necessary information and support to the participant to ensure he or she directs the process to the maximum extent possible and is enabled to make informed choices and decisions.

c. Is timely and occurs at times and locations of convenience to the participant.

d. Reflects cultural considerations of the participant and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient.

e. Includes strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants.

f. Providers of Waiver services for the individual, or those who have an interest in or are employed by a provider of Waiver services are not also responsible for developing the POT, except when the Contractor demonstrates that they are the only willing and able entity available to develop the POT, and have been authorized to do so by DHCS.
Exhibit A – Attachment I
Waiver Administrative Services

g. Offers information to the participant so he or she can make informed choices about the services and supports he or she receives, and about available providers.

h. Includes a method for the participant to request updates to the plan, as needed.

i. Records each of the alternative home and community-based settings that were considered by the individual.

2) Opportunity for Participant-Directed Services

HCBA Waiver participants or their legal representative have the opportunity to select and dismiss licensed and unlicensed care providers who, under the direction of the participant or legal representative, can provide waiver services as described in Appendix C of this application. HCB Waiver Alternatives participants can elect to terminate participant direction of services at any time.

a. Involuntary termination of participant-directed services must always be authorized by DHCS. The Contractor must submit requests to terminate participant-directed services to DHCS with a clear explanation of the need to terminate participant-directed services and supporting documentation. Some incidents that may contribute to the need to terminate participant-directed services include, but are not limited to:

i. Lack of a participant’s current primary care physician-signed POT describing all the participant’s care services, provider(s) of services, and/or the frequency of the services;

ii. Participant or legal representative require the provider to provide services that are not included in the POT or beyond the scope of practice of the licensed provider; and

iii. Participant or legal representative are unable to keep providers as demonstrated by frequent voluntary termination of the services by the provider, and/or the participant's or legal representative's refusal to follow the provider enrollment process as described in the provider information packets.

b. Contractor shall provide the participant with a NOA informing him or her of the DHCS-authorized decision to terminate participant-directed Waiver
services and/or enrollment, as well as his or her appeal rights.

c. Contractor shall ensure safeguards to ensure participant health and welfare, and the continuity of services during the transition of service provider(s). These safeguards must include documented coordination between DHCS, the Contractor, the CMT, and the existing and/or new provider(s) to ensure the quality of care is maintained and there is no break in services.

B. Freedom of Choice

In compliance with 42 CFR §431.51, Contractor shall:

1) Ensure all participants are given the option to select any willing and qualified service provider to provide Waiver services included in their POTs;

2) Establish and implement policies and procedures for assuring that willing and qualified providers (selected by participants to provide Waiver services included in their POTs) will be paid at least the Medi-Cal fee-for-service rate for providing authorized Waiver services, even if the provider refuses to enter into a network provider subcontract;

3) Ensure willing and qualified providers who choose not to subcontract with the Contractor are not excluded from providing HCBA Waiver services. HCBS providers may bill Medi-Cal directly, rather than through the Waiver Agency; however, authorization to provide services must be adjudicated through the Waiver Agency and the provider must provide proof of the service authorization from the Waiver Agency when submitting claims to the Medi-Cal Fiscal Intermediary (FI) for payment;

4) Enter into sub-contracts with a sufficient number of HCBS providers within the service area, for each Waiver service, and with willing and qualified providers selected by the participant.

5) Ensure the participant and/or legal representative is advised of the participant’s right to assess the performance of any provider. Contractor shall also ensure a process is in place to allow the participant or legal representative to inform the CMT and/or the Contractor of any issues or problems with the provider(s), and to notify the appropriate law enforcement agency, child or adult protective services, county In-Home Supportive
C. Circle of Support

Contractor must ensure their CMTs assist Waiver participants in identifying and establishing a circle of support comprised of individuals and/or organizations willing and able to support the participant in the community. A circle of support may consist of community-based organizations, family members, licensed foster parents, and/or anyone identified by the participant who is willing to provide support. Individuals and organizations included in a participant’s circle of support are unpaid. In this context “support” may include, but is not limited to:

1) Providing emotional support and/or companionship
2) Checking on the participant to ensure he or she does not become isolated
3) Bringing the participant into the community
4) Staying with the participant in the event of an emergency

D. Backup Waiver Service Providers

Contractor must develop and maintain a system to ensure qualified backup Waiver service providers are available to provide authorized services to Waiver participants in the event that the scheduled Waiver provider is not available, or does not arrive at the scheduled time.

E. Continuity of Care

1) Contractor shall develop and institute processes and policies for their CMTs to ensure there are no gaps in participants’ care when an individual:
   a. Transitions onto the Waiver
   b. Changes providers of authorized services identified in the POT
   c. Discharges from a short-term institutionalization

2) Some of the ways the Contractor shall ensure continuity of care include, but are not limited to: appropriate and timely referrals of participants needing specialty health care services, documentation of referral services in participant case records, monitoring participants’ medical appointments, documentation of participant emergency medical encounters, etc.

F. Safe Home Environment
Exhibit A – Attachment I
Waiver Administrative Services

1) Contractor shall ensure the safety and accessibility of the applicant or participant’s living environment, and submit a home safety evaluation to DHCS with the initial Waiver application and service needs evaluation.

2) Contractor shall complete a home safety evaluation to determine if the participant’s home environment is safe and conducive to the successful implementation of a home and community-based services program.

G. Community Integration

Contractor shall ensure and uphold all provisions within the Centers for Medicare & Medicaid Services CMS’ home and community-based (HCB) settings regulations that define HCB settings based on individual experience and outcomes with the purpose of maximizing the opportunities for individuals receiving Medi-Cal HCB services to receive those services in community-integrated settings.

1) Non-Provider Owned or Controlled Setting

Consistent with CMS’ HCB settings rules, non-provider-owned or controlled private residential home settings qualify as HCB settings, because: the Waiver participants are able to access the benefits of community living, including opportunities to seek employment and work in competitive integrated settings; these settings do not isolate the participant from the broader community, and do not have the characteristics of an institution; and these settings do not control the personal resources of the participant, or utilize interventions or restrictions that exist in institutional settings.

The following types of non-provider owned or controlled private residential settings qualify as HCB settings:

a. Private residences owned, leased or rented by the participant, a relative of the participant, a conservator, or any other individual legally authorized to represent the participant.

b. A Single-family home, apartment, rental unit, or any other residential space in the greater community.

c. A private residence where the participant pays for part, or all, of the lease with the assistance of federal, State, or local funding.
Exhibit A – Attachment I
Waiver Administrative Services

2) HCBA Waiver Provider Owned/Controlled Setting - Congregate Living Health Facility (CLHF) Requirements

Consistent with CMS' HCB settings rules, provider-owned or controlled settings do not qualify as HCB settings; therefore, the Contractor must ensure all of the following:

a. Participants must be given the ability and necessary support to allow them full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medi-Cal HCBS.

b. Participants must have the opportunity to select from among various setting options, including non-disability specific settings, and an option for a private unit in a residential setting.

c. Contractor must uphold and protect the participants' rights of privacy, dignity and respect, and freedom from coercion and restraint.

d. Contractor must optimize the autonomy and independence of participants in making life choices, including daily activities, physical environment, and with whom to interact.

e. Contractor must facilitate choice regarding the participants' services, supports, and providers.

3) Medi-Cal Provider-Owned/Controlled Residential Setting

Consistent with CMS' HCB settings rules, Medi-Cal provider-owned or controlled residential settings do not qualify as HCB settings; therefore, the Contractor must offer all of the following:

a. A legally enforceable agreement between the provider and the participant that allows him or her to own, rent, or occupy the residence, and to be protected against eviction.

b. Privacy in units including lockable doors, choice of roommates, and freedom to furnish and decorate the unit.

c. Options for participants to control their own schedules including access
Exhibit A – Attachment I
Waiver Administrative Services

to food at any time.

d. Freedom to have visitors at any time.
e. A physically accessible setting.

4. Resolution of Issues

A. Event/Issue Report

1) Contractor, in conjunction with the CMT, will act on and document all reported or observed critical events or issues that may affect the health, safety, and/or welfare of Waiver participants or their service/care providers, as they are discovered.

2) Critical events or incidents are incidents of participant abuse, (verbal, sexual, physical, or mental) or neglect, incidents posing an imminent danger to the participant or service/care provider(s), fraud or exploitation (including misuse of participant’s funds and/or property), or a dangerous physical environment.

3) Contractor is required to report immediately all incidents of possible abuse, neglect, or exploitation to the appropriate local or State agencies such as Adult Protective Services (APS), Child Protective Services (CPS), local law enforcement, the California Department of Public Health (CDPH) Licensing and Certification (L&C) Division, as well as DHCS.

4) Contractor must document all critical events or incidents, which includes reports, referrals, and follow-up by the Contractor, in the participant’s case record, documentation must also include the agency and person(s) who received the report and the person(s) responsible for conducting the investigation.

5) If the Contractor and/or subcontractor is informed of, witnesses, or has reason to believe that a Waiver participant suffered an incident of abuse, as defined in Welfare & Institutions Code section 14043.1(a), or negligence by someone present in the CLHF, the Contractor must report the information to DHCS using the Event/Issue Report form within one business day. DHCS will work with the Contractor to investigate the facts of the incident, and if appropriate, remove Waiver participant(s) from the facility. The Contractor will coordinate with DHCS A&I to implement a temporary suspension of new enrollments if DHCS determines that such an action is appropriate. DHCS
Exhibit A – Attachment I
Waiver Administrative Services

will continue to pay the facility for the participant up to one month after the initiation of the temporary suspension, or until the participant is relocated, whichever occurs first.

B. When directed to do so by DHCS, Contractor will identify an alternate placement location and will work in coordination with DHCS to move the Waiver participant to the alternate location within 30 days. During this 30-day period, the Contractor and the CMT will continue to work with the Waiver service providers, the participant’s current primary care physician, the participant and her or his legal representative, and circle of support to ensure that the participant receives his or her medically necessary services. If there is an imminent danger to the participant, immediate removal from a CLHF can be actuated by working in coordination with DHCS, APS/CPS and the local Ombudsman, as DHCS deems appropriate to the situation. This placement may be temporary until an alternative, permanent, and safe residence is secured for the participant. The CMT will continue to visit the participant in the facility to ensure his or her safety throughout the transition process.

C. California’s CPS and APS programs have primary responsibility to resolve reported events/incidents of abuse, neglect, and/or exploitation. In the event that CPS or APS does not take timely and appropriate action, the Contractor will notify local law enforcement if the issue continues. APS and CPS conduct investigations independently from DHCS and according to their own timeline. Their timeframe and processes for informing necessary parties of the results of any investigations, including Medi-Cal, are on an “as requested” basis. When CPS, APS, and/or local law enforcement are involved, Contractor is required to continue to monitor the Waiver participant's health and safety to ensure he or she continues to receive all medically necessary waiver services to maintain the participant safely in the community, if possible, or arrange for the participant to transfer to a facility if safe community placement cannot be accomplished.

D. Incident Reporting to State Agencies

1) Contractor must use the Event/Issue Report form to communicate with DHCS and the CDPH L&C Division on events/issues affecting participants that involve HHAs, CLHFs, and CHHAs. L&C will determine if the provider is in compliance with the California Health and Safety Code Sections 1736-1736.7
Exhibit A – Attachment I
Waiver Administrative Services

(CHHA), 1760-1761.8 (PDHC), 1250(i) (CLHF). After the Contractor consults with DHCS, DHCS forwards the completed confidential Event/Issue Report to L&C with a request that L&C investigate when there has been:

a. Failure by the service provider to report abuse or neglect of a participant. L&C will also notify the appropriate local or State agencies.

b. Failure to notify the participant’s current primary care physician of a change in the participant’s condition, if the participant is harmed by the failure of this action.

c. Failure to inform the participant and/or his or her legal representative/legally responsible adult(s) of the participant’s “Patient Rights”;

d. Failure to comply with the participant’s “Patient Rights”; 

e. Failure to complete the appropriate documentation and/or notify the participant’s current primary care physician of an incident;

f. Failure to provide services or supplies included in the POT, ordered by the participant’s current primary care physician, and that the provider agreed to provide;

g. Inadequate or inappropriate evaluation of the participant’s needs (e.g., weight loss not assessed);

h. Inadequate notification to the participant when services or supplies are changed or terminated; and,

i. Failure to act within a professional’s scope of practice.

2) Contractor will continue to work with Waiver service providers, the participant’s current primary care physician, and the participant during L&C’s investigation, to ensure the participant receives needed services and is able to continue to reside safely in the home.

3) Contractor shall implement and maintain written grievance policies and procedures describing the submission, documentation, evaluation, and resolution of all participant grievances.

E. Responding to Verbal and Written Complaints

1) A verbal complaint consists of any expression of dissatisfaction by a
Exhibit A – Attachment I
Waiver Administrative Services

participant to the Contractor or subcontractor, in person or by telephone.

2) The Contractor and/or subcontractor responds to verbal complaints verbally. Verbal complaints are usually resolved within 72 hours. The Contractor and/or subcontractor is responsible for documenting the verbal complaint and resolution.

3) A written complaint is considered a formal complaint and consists of any written expression of dissatisfaction by a participant to the Contractor and/or subcontractor.

4) When written complaints are received, the Contractor must record each complaint in a complaint log. Different levels of staff may be involved in the written complaint review process.

5) Contractors must provide written assurances that any participant who requests or needs assistance with the submission of a complaint shall receive it.

6) All Contractor complaint policies and procedures must be provided to the participant and/or the participant’s legal representative, in writing, at the time of enrollment and upon request, and must address/include the following:

   a. A description of the process and general timelines for complaint resolution. The Contractor must provide DHCS’ accurate contact information to a participant upon request.

   b. Written information about the Contractor’s grievance policies, procedures, and form(s), must be provided to the participant at the time of enrollment and upon request; and, must include telephone numbers for obtaining information on State Fair Hearing appeal rights.

   c. All grievances must be brought to the attention of the participant’s CMT for first-level resolution, and must be included in the next QAR.

   d. All grievances must be reviewed by the Contractor following the submission of the grievance, and appropriate action, as outlined below.

   e. If a verbal complaint cannot be resolved by the participant’s CMT, the CMT must document the grievance and treat it as a formal,
written complaint.

f. If a verbal complaint becomes a written complaint, the Contractor must notify DHCS of the grievance in the subsequent Quarterly Performance Report (QPR) and provide DHCS information pertaining to the case. If the grievance is resolved, the Contractor must notify DHCS of the resolution that was reached and/or the outcome.

g. Contractors must immediately report serious issues involving licensed providers to DHCS in writing.¹

h. If a participant is unwilling to substantiate a complaint, or provide details necessary to perform an investigation, the Contractor is not obligated to continue investigating the complaint and/or seek resolution, and may close the case. The Contractor shall notify the participant of its decision in writing.

7) Contractor will keep the participant and/or his or her legal representative or legally responsible adult(s) informed of the progress of the investigation and will continue to follow-up with the participant until the issue is resolved. If the issue is not resolved within 30 days, the Contractor will discuss the issue(s) with DHCS and develop an alternative plan for resolution.

8) If the Contractor is notified of a complaint that constitutes a critical incident that occurred in a facility within the Contractor’s provider network, the Contractor must complete an Event/Issue Report form, immediately report the incident to the appropriate local agency, and send the report to DHCS by email or by mail within two business days.

9) Contractors are required to submit a list of grievances and complaints that have been filed and resolution of the grievances and complaints to DHCS on a quarterly basis as part of their QPRs.

10) Contractor’s grievance policies and procedures are subject to review and approval by DHCS during QAR and as necessary. DHCS provides technical assistance to Contractors handling complaints, grievances, and complicated situations. Contractors report all complaints, grievances, and outcomes in their QPRs.

11) Contractor shall instruct participants on how and when to notify the

¹ DHCS immediately reports serious incidents involving licensed providers to CDPH L&C.
Exhibit A – Attachment I
Waiver Administrative Services

Contractor if the participant is subjected to abuse, neglect, or exploitation.

12) Contractor shall instruct participant on how to report abuse, neglect, or exploitation to the appropriate authority.

13) If the Contractor’s CMT observes or learns that restraints are being used on a participant, the CMT must:
   a. Determine within 24-hours:
      1. If the use of restraints is ordered by the participant’s current primary care physician;
      2. If a plan with criteria for the use and monitoring of restraints is documented in the participant’s POT; and
      3. If the plan is being followed by the caregivers and/or providers.
   b. Complete an Event/Issue Report, submit a copy to DHCS, and include the report in the participant’s case file.

F. Use of Restraints

1) Contractor must maintain policies and procedures regarding provider use of restraints that reflect state laws, regulations, and policies and include provider training requirements.

2) The Contractor’s CMT will ensure the providers/caregivers in the home have been adequately trained in the application and monitoring of physical restraints. This is achieved by home visits to observe the participant, evaluate caregiver competency, and review of the POT.

3) The use of physical restraints must be supported by a specific assessed need and justified in the POT. If restraints are being used, the following information must be documented in the POT:
   a. A specific and individualized assessed need for the restraints.
   b. The positive interventions and supports used prior to any modification(s) to the person-centered service plan.
   c. The less restrictive methods that were attempted to meet the identified need, and explain why they were not successful.
   d. A clear description of the condition/diagnosis that is directly proportionate to the specific assessed need.
Exhibit A – Attachment I  
Waiver Administrative Services

e. Regular collection and review of data to measure the ongoing effectiveness of the modification(s).

f. Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

g. Documented informed consent of the individual and/or his or her legally authorized representative if the individual is unable to give informed consent.

h. Include an assurance that the restraints, interventions, and supports will cause no harm to the participant.

4) Contractor shall provide training to the CMT on the legal use of restraints based on the requirements included above. Training must be conducted at least annually, and the dates of each training and all who attended must be documented.

5) Contractor will ensure the CLHF maintains internal policies and procedures that include staff education and training in the administration and monitoring of restraints. A CLHF may use physical restraints only in compliance with state and federal regulations and statutes.

6) If a facility is found to have used unauthorized restraints, the Contractor will assist Waiver participants and/or authorized representatives to arrange for appropriate alternative placement, and will report the incident to DHCS, CDPH, adult or child protective services, and law enforcement.

7) If the Contractor determines that physical restraints used for a participant living in his or her home are appropriately authorized, but the POT does not address preventative interventions, the Contractor’s CMT will assist the participant or legal representative to identify alternative methods specific to the participant for inclusion in the POT, and as ordered by the physician.

8) If the Contractor determines that the participant’s current primary care physician has not authorized the use of restraints, or the use of the restraints is not in compliance with the POT, the Contractor’s CMT must notify DHCS of that fact in writing within two business days, and contact appropriate law enforcement and child or adult protective services to report the incident.
Exhibit A – Attachment I
Waiver Administrative Services

G. Medication Management

1) Contractor must work with the CLHF to ensure the nursing staff is responsible for the administration of medications for HCBA Waiver participants, and that they are trained to ensure appropriate medication management and client education. Monitoring medication management and administration is to detect potentially harmful practices through ongoing onsite review and evaluation of medication related policies, procedures, documentation, and clinical practices. Monitoring of medication management in a CLHF is conducted by CDPH, DHCS, and the Contractor.

2) The Contractor shall document all findings of harmful and/or noncompliant medication management practices within the CLHF, follow up with DHCS with a plan for resolution, and track remediation efforts to improve program performance in all community settings. To help ensure proper medication management and administration, the Contractor, DHCS, and CDPH review the following:
   a. Medication storage;
   b. Self-administered medications;
   c. Medication procedures;
   d. Medication documentation;
   e. Scheduled and controlled drugs, usage and storage; and
   f. “As needed” medications, usage and disposal.

3) The Contractor shall collect, follow-up on, and report medication errors on a quarterly basis in the QPR.

H. Notice of Action (NOA)

1) Contractor will issue a NOA form to the HCBA Waiver participant for the following reasons, among others:
   a. The participant loses Waiver services because of changes to his or her Medi-Cal eligibility.
   b. Waiver services are denied or modified, or when previously approved services are reduced.
   c. There is no evidence establishing the medical necessity for the
requested Waiver services.

d. The participant moves from the geographical area in which the HCBA Waiver services were authorized to a new area where there is no contracted Waiver Agency. In this circumstance, the NOA will inform the participant that he or she must contact DHCS to be re-enrolled in the waiver to receive Waiver services administered by DHCS.

e. The participant's medical condition is unstable, as demonstrated by frequent emergency department visits and/or unplanned hospitalizations, and the Waiver providers are unable to provide enough medically necessary services and supports to ensure the participant’s health and safety in the community.

f. The participant's condition does not meet the medical LOC eligibility criteria required in the Waiver.

g. The participant or the legal representative refuses to comply with the participant’s current primary care physician's orders in the POT, and the Contractor or DHCS determines that such compliance is necessary to assure the health, safety, and welfare of the participant.

h. The participant or the legal representative does not cooperate in attaining or maintaining the POT goals, thereby jeopardizing the participant’s health and welfare.

i. The identified support network system or a backup caregiver cannot be identified, is not able, or is no longer willing or available, to assume the responsibility to act as a back-up caregiver for the participant. When this happens, the Contractor will work with the participant and responsible persons to develop a POT and identify providers so the participant can continue to reside safely in a home-like setting, when possible.

j. The home safety evaluation completed by the CMT documents an environment that does not support the participant’s health, safety, and welfare, or is otherwise not conducive to the provision of HCBS Waiver services.

k. The Waiver service providers are unwilling or unable to provide the amount of authorized services in the participant's POT and/or primary
care physician's order. If a provider's unwillingness or inability to provide the amount of services authorized in the POT, and the reduction of services impacts the participant's health or safety, the Contractor shall work with the participant to identify a licensed health care facility in which he or she can receive services until another Waiver service provider is able and willing to provide the entire amount of authorized services to the participant in a home or community setting.

l. The Contractor, direct service provider, or DHCS finds the participant to be a threat or harmful to others, including but not limited to, caregivers or service providers, care managers, or the community at large; or is unable to ensure the health and safety of the participant’s circle of support.

m. The participant or their legal representative and circle of support are requesting direct care Waiver services that exceed 24 hours per day, and do not agree to a reduction of services so as not to duplicate services.

n. The participant receives 360 hours per month of combined IHSS and WPCS, does not have two (2) or more personal care providers, and has not submitted and obtained an exemption request through DHCS, in compliance with Section 12300.4 of the WIC.

o. Contractor does not submit a complete and current POT that is signed by the participant’s current primary care physician within 90 days of notification that they are eligible for enrollment in the HCBA Waiver, or within 60 days of the end-date of the previous POT.

p. Contractor and DHCS have not authorized a Waiver service within 90 days of notification that the participant is eligible for enrollment in the HCBA Waiver, or within 60 days of the termination date of the last authorized Waiver services.

q. An enrolled Waiver participant returned to an institutional setting for more than 30 consecutive days.

I. Appeals and Fair Hearing Process

1) The NOA form must advise the participant of the decision and the reason(s) to:
Exhibit A – Attachment I
Waiver Administrative Services

a. Terminate or deny Waiver enrollment; or
b. Reduce, terminate, or modify requests for Waiver services or benefits.

2) The NOA includes instructions advising the participant and/or his or her authorized representative(s) on how to request a State Fair Hearing before an Administrative Law Judge (ALJ).

3) The participant must request a State Fair Hearing within 90 calendar days after the date the NOA is mailed. The request must be received within ten calendar days for the participant to continue receiving services as previously authorized without interruption.

4) The NOA must inform the participant or legal representative that he or she is responsible for submitting the request for a State Fair Hearing before the action takes place.

5) A copy of the NOA and the Fair Hearing request form must be filed in the participant’s case record maintained by the Contractor.

6) DHCS shall notify the Contractor when a participant or legal representative has requested a State Fair Hearing in response to the Contractor’s decision to deny, modify, or reduce Waiver services. Contractor shall provide written position statements about their decisions to deny, modify, or reduce Waiver services, and shall designate staff to act as its representative and to provide testimony at State Fair Hearings at the scheduled time and place of the State hearing. Contractor responsibilities regarding State Fair Hearings are pursuant to Welf. & Inst. Code sections 10950 through 10962, and Cal. Code Regs., tit. 22, sections 51014.1, 51014.2, 53261 and 53452. Additional clarification of Contractor responsibilities related to State Fair Hearings shall be provided to Contractor by DHCS.

5. Corrective Action Plans (CAP) and Quality Assurance Reviews (QAR)

A. Contractor must cooperate with DHCS in the review and approval of initial waiver enrollment determinations, changes to participants’ eligibility, and ongoing monitoring and oversight of sub-contracted CMTs and network providers.

B. Contractor shall monitor the provider network to ensure providers maintain
Exhibit A – Attachment I
Waiver Administrative Services

Medi-Cal enrollment, that they have not been suspended, and that they are providing the services as authorized and as described in the POT.

C. The Contractor shall issue a CAP to a Waiver service provider when the Contractor, or DHCS, identifies issues of noncompliance through regular monitoring and oversight. The Contractor and DHCS will monitor and follow-up on the CAP until the issue is resolved.

D. Contractor shall ensure the CAP is specific about the actions to be taken, the personnel who will take the actions, and when the corrective action will be completed.

E. Upon receipt of the CAP, DHCS monitors the Contractor’s resolution process to ensure complete remediation of the deficiency.

F. Once the CAP is reviewed by DHCS, the Contractor is given an opportunity to implement the developed strategy.

G. Once a CAP is implemented, DHCS may conduct an on-site follow-up visit to the Contractor to evaluate the effectiveness of the new practice, and/or may request additional records for review.

H. Contractor will not receive a CAP approval letter until complete resolution has been verified by DHCS. Technical assistance is provided throughout the process on an as-needed basis.

I. DHCS performs biennial onsite reviews for each Contractor, called Quality Assurance Reviews (QARs).

J. During the QAR, DHCS reviews the Contractor’s case files to ensure that all required performance measures are being met; confirm that assessments, reassessments and authorizations are performed on a timely basis; confirm that provider payments align with set rates and negotiated agreements; verify the resolution of grievances/appeals and special incidents; etc.

K. DHCS will also schedule Waiver participant and provider interviews while onsite. If a CAP is required DHCS will notify the Contractor in writing following the QAR.

L. DHCS aggregates the results of the QARs and discovery information to develop a statewide remediation approach that includes policy dissemination through the periodic Contractor meetings, the HCBA Waiver Agency Manual updates and policy letters, if needed. DHCS uses this aggregate data to...
Exhibit A – Attachment I
Waiver Administrative Services

prioritize training needs to schedule multi-Waiver Agency training events.

M. DHCS also provides technical assistance onsite or through on-going email and telephone contact between the Contractor and DHCS.

N. DHCS regularly reviews provider payments as part of the internal monitoring and oversight.

O. Claims data is stored in the DHCS Data Warehouse and allows DHCS to monitor the services being provided, at what frequency, and to which participants. This information allows the State to validate the information documented in participants’ POTs and in the service needs evaluations and care management acuity level assessments.

P. If DHCS finds a discrepancy through the claims monitoring and validation process, an audit may be triggered prior to the biennial scheduled QAR.

Q. DHCS shall collect QPRs from the Contractor, which must include enrollment levels, fiscal performance, and quality assurance activities.

R. DHCS shall ensure HCBA settings meet the CMS final rule described in the Statewide Transition Plan (STP).

6. Minimum Program Requirements

A. Contractor must be an active Medi-Cal provider in good standing with Medi-Cal. For the purposes of this Agreement, “good standing” shall mean that the Contractor’s Medi-Cal provider number has not been de-activated or suspended, temporarily or permanently.

B. Contractor must maintain a participant caseload ratio that complies with the caseload thresholds in Provision 3. Care Management Team Caseload Thresholds, in Exhibit A, Attachment II of this Contract.

C. Contractor shall maintain employees and/or contracted providers assigned specifically to the HCBA Waiver program and shall ensure the following minimum staffing requirements:

1) The Contractor shall designate a local HCBA Waiver program lead who shall assume, but not be limited to, the following responsibilities:

a. Provide oversight of the day-to-day operations of the Contractor’s HCBA Waiver program to ensure their organization remains in compliance with the terms of this Agreement;
b. Ensure appropriate, trained personnel perform their functions within the organization;

c. Notify and provide on-going updates to employees and contracted providers on the local HCBA Waiver program’s policies and procedures; and

d. Attend DHCS meetings, teleconferences, and trainings; or ensure a knowledgeable proxy attends in the place of the program lead to ensure the transfer of information.

2) Contractor shall maintain RNs licensed to practice in the State of California, in the number sufficient to be part of a CMT and provide Comprehensive Care Management services to HCBA Waiver participants in the Contractor’s assigned geographical area.

3) Maintain Social Workers with at least a Master’s Degree in Social Work (MSW) in the number sufficient to be part of a CMT and provide Comprehensive Care Management Services to HCBA Waiver participants in the Contractor’s assigned geographical area.

4) Maintain sufficient support staff to conduct Contractor's daily business in an orderly manner.

D. Contractor shall maintain and have on file up-to-date duty statements for all employees assigned to work on the HCBA Waiver Program, and a written description and an organizational chart that outlines the structure of supervision and authority within the program and under the parent organization. If Contractor is planning a change in the organizational structure, Contractor must provide DHCS with written notification of the planned change at least 14 calendar days before the change would take effect.

E. Contractor shall establish and maintain its own policies and procedures (P&Ps) on the ways in which the organization implements the HCBA Waiver Program in compliance with the approved 1915(c) HCBA Waiver, state and federal law, and the terms of this Agreement. Contractor’s P&Ps must remain current, through ongoing updates and revisions based on official DHCS Policy and Guidance Letters and/or contract amendments. The Contractor’s P&Ps shall be available to DHCS upon request; and must, at a minimum include:

1) The assurance that all Medi-Cal members transitioned to the community
Exhibit A – Attachment I
Waiver Administrative Services

are informed that they must have a community primary care provider within 60 days after the date of the transition to continue participation in the Waiver.

2) Descriptions of how the organization will:

a. Monitor the coordination of care provided to participants, including but not limited to, all medically necessary Medi-Cal and non-Medi-Cal services.

b. Provide and track training provided to staff and subcontracted service providers.

c. Distribute/communicate HCBA Waiver program updates to staff and subcontracted service providers.

d. Collect and respond to verbal and written participant complaints and grievances.

e. Collect and report incidents or events to DHCS that threaten the welfare, safety, or health of any participant or provider. Examples of reportable incidents include injuries, abuse, neglect, exploitation, and medication errors.

f. Maintain and secure participant records, which must include, but shall not be limited to:

   i. Storing and securing records containing protected health information (PHI) and personal confidential information (PCI) in compliance with this contract as well as state and federal law, including but not limited to the Health Insurance Portability and Accountability Act (HIPAA); and

   ii. Release of information and obtaining consent to access members’ protected personal information.

g. Develop and maintain documented protocols to manage medical and nonmedical emergencies and disasters that are likely to threaten the health or safety of the members, and for obtaining emergency medical assistance from sources outside the Contractor’s organization and/or working hours, when needed.

F. Participant Case Files
Contractor shall utilize MedCompass (see sub-provision I. below) to maintain an up-to-date, centralized, secured case file record for each Waiver participant, as outlined in the HCBA Waiver Provider Manual available on the DHCS webpage. Contractor shall implement and maintain a system to review case files for compliance with Waiver requirements and delegate an individual to be responsible for the reviews.

G. Training

1) Contractor shall ensure all service providers receive information or training regarding the HCBA Waiver program to enable full compliance with approved 1915(c) HCBA Waiver application, state and federal statute, and the terms of this Agreement.

2) Contractor shall ensure provider training relates to HCBA Waiver services, policies, procedures, and any modifications to existing services, policies or procedures; and that it is conducted within 10 working days after hiring new service providers or entering into a new, standardized subcontract for services.

3) At a minimum, Contractor shall ensure service provider training includes information on all participant rights specified in this Contract, including the participant’s right to full disclosure of available options for care and the right to actively participate in health care decisions.

4) Contractor shall ensure that ongoing information or training is provided when deemed necessary by the Contractor or DHCS.

5) Contractor shall maintain a record of all training provided to employees and subcontractors providing services under this Agreement. The training record must include the subject matter and date(s) of the training, and the name, title, affiliation, and contact information of every attendee. Contractor’s training record shall be available to DHCS upon request.

H. Information Technology Requirements

Contractor shall secure, at its own cost, local information technology support services and infrastructure that include but are not limited to, the following:

1) System Capacity
   a. Computer software that is compatible with Microsoft Office version
2010, software compatible to open and read portable document format (PDF) documents, and encryption software to ensure PHI/PII is secure when transferring electronic information to, or receiving electronic information from contracted Waiver providers.

b. Telecommunications, hardware, and network security, including but not limited to, the ability to send and receive zipped, secure, and encrypted communication and data, which may contain PHI/PCI.

c. Security patches and upgrades as they become available to keep virus software up-to-date on all systems.

I. Management Information System (MIS)

1) Contractor shall utilize the Management Information System known as MedCompass that has been created to support DHCS Waiver programs. MedCompass assists case managers, support staff, and management to oversee and manage cases covered under the HCBA Waiver.

2) The MedCompass tool will provide automation that will facilitate reporting, the creation of letters and forms, secure messaging and email between the Contractor and DHCS staff, as well as capabilities for alerts, task assignments and queues that will provide immediate notifications between the Contractor and DHCS.

3) The MedCompass solution is HIPAA compliant and meets the capabilities for the Care Management business area as required in CMS’ Conditions and Standards - 42 CFR §433.112(b)(10)-(16) and the new conditions at § 433.112(b)(17)-(22).

4) MedCompass enables DHCS and the Contractor to provide Administration and Comprehensive Care Management to HCBA Waiver participants in designated geographical locations to:

   a. Provide secure access to MedCompass from within a private cloud infrastructure

   b. Web based access for nursing staff in the field performing patient reviews and assessments for treatment

   c. One comprehensive system for easier tracking and program reviews

   d. Centralizing Care Management data to reduce redundancy and
Exhibit A – Attachment I
Waiver Administrative Services

increasing the ability of divisions and contracted providers to leverage and share data

e. Standardization of Medical Treatment Referrals
f. Automation of the Business Process
g. Maintaining of case files electronically
h. Enabling electronic communications between DHCS staff and Waiver Agencies
i. Completing assessment reports electronically
j. Calculating “Utilization of approved annual amount of care” electronically
k. Maintaining treatment plans electronically
l. Access to Medi-Cal eligibility data on all Waiver participants
m. Contracted provider claims status and payments data; and
n. Provider network information

J. MedCompass Requirements

MedCompass is an integrated Care Management Commercial Off the Shelf (COTS) Cloud-Based Software as a Service (SaaS) with comprehensive features and functions specifically designed to support government-sponsored healthcare programs and is an integrated care management tool with functionality for utilization management, case management, disease management, population health, wellness management, and eligibility.

MedCompass is built on a service-oriented architecture (SOA) 100 percent Web-based technology platform, consisting of the latest Microsoft technologies, and scalable to meet the needs of DHCS and its partners.

Contractor will share data with DHCS via MedCompass and will, therefore, be required to have and maintain, at its own cost, all of the following IT components:

1) Microsoft Office
2) Microsoft Silverlight – a free download necessary for the operation of MedCompass
3) Internet Explorer
7. Contractor Readiness Review and Operational Start Date

DHCS will conduct a Readiness Review of each Contractor that will include a review of the Contractor’s HCBA Policies and Procedures (HCBA) Manual, and a minimum of one on-site review. The intent of the Readiness Review is to verify the Contractor’s assurances that the Contractor is ready and able to meet its obligations under the Contract. Prior to DHCS transferring the responsibility of HCBA Waiver Administration and the provision of Comprehensive Care Management services to the Contractor, the Readiness Review must be complete and the Contractor must possess a written Operational Start Date Authorization Notice from DHCS. Contractor will not be compensated for any services performed or work undertaken prior to the Operational Start Date listed on the written Operational Start Date Authorization Notice issued by DHCS to the Contractor, including but not limited to any services or work compensated through the Administrative or Comprehensive Care Management flat rate per payments.

A. The scope of the Readiness Review will include, but is not limited to, a review of the following elements:

1) Waiver Administration

Contractor must not provide HCBA Waiver Administrative Services until DHCS has evaluated all of the following Administrative Readiness Deliverables and provided the Contractor an Operational Start Date Authorization Notice.

<table>
<thead>
<tr>
<th>Administrative Readiness</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Network Provider Composition and Access</td>
<td>List of HCBS Providers that includes the type(s) of Waiver service(s) they provide (i.e. habilitation, nursing services, respite, etc.)</td>
</tr>
<tr>
<td>2. Staffing Capacity and Qualifications</td>
<td>Organization chart, hiring process (i.e. criminal background checks (Live Scan) and licensure verification), and duty statements</td>
</tr>
</tbody>
</table>
### Administrative Readiness Deliverables

<table>
<thead>
<tr>
<th>Administrative Readiness Deliverables</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. HCBA Waiver Administrative Policies and Procedures (P&amp;Ps) Manual</td>
<td>HCBA Waiver administrative P&amp;Ps with required content</td>
</tr>
<tr>
<td>4. Staff Training</td>
<td>In-service materials and training logs</td>
</tr>
<tr>
<td>5. Quality Assurance / Performance Improvement Plan</td>
<td>Quality Assurance / Performance Improvement Plan</td>
</tr>
<tr>
<td>6. Billing and Reimbursement Systems</td>
<td>Observation of database and systems, and P&amp;Ps specific to billing and reimbursement under the HCBA Waiver</td>
</tr>
<tr>
<td>7. Information System(s) / Security</td>
<td>Observation of information system(s) / security, and P&amp;Ps specific to safeguarding PHI/PII under the HCBA Waiver</td>
</tr>
</tbody>
</table>

2) Comprehensive Care Management

Contractor must not provide Comprehensive Care Management Services until DHCS has evaluated all of the following Comprehensive Care Management Readiness Deliverables and provided the Contractor with an Operational Start Date Authorization Notice.
### Exhibit A – Attachment I
Waiver Administrative Services

<table>
<thead>
<tr>
<th>Comprehensive Care Management Readiness Deliverables</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Care Management Team(s) Ratios</td>
<td>Staffing-to-Waiver Population Ratios Included in the P&amp;P Manual</td>
</tr>
<tr>
<td>2. HCBA Waiver Comprehensive Care Management P&amp;Ps</td>
<td>HCBA Waiver Comprehensive Care Management P&amp;Ps with Required Content</td>
</tr>
<tr>
<td>3. Home Visit / Participant Contact Tracking</td>
<td>Schedule and P&amp;P Manual</td>
</tr>
<tr>
<td>6. Care Management Acuity Assessment</td>
<td>P&amp;P Manual</td>
</tr>
<tr>
<td>7. Menu of Health Services (MOHS)</td>
<td>List of Providers’ Contact Information and the HCBS they are Authorized to Provide</td>
</tr>
<tr>
<td>8. HCBA Waiver Community Outreach</td>
<td>Examples of HCBA Waiver Community Outreach Materials</td>
</tr>
<tr>
<td>10. Utilization of MedCompass</td>
<td>Successful use of the MedCompass Care Management System by users</td>
</tr>
</tbody>
</table>

#### B. Operational Start Date Authorization Notice

Once DHCS has determined that the Contractor has successfully completed all of the Readiness Deliverables, DHCS will issue the Contractor an official Operational Start Date Authorization Notice that will be incorporated into this Contract by reference.

#### C. Remediation of Deficiencies
Exhibit A – Attachment I
Waiver Administrative Services

If DHCS determines that the Contractor has not successfully completed one or more Readiness Deliverables, DHCS will inform the Contractor, by email, of the areas where the Contractor is not ready and able to meet its obligations under the Contract, and the Contractor will have 30 days to correct all deficiencies, from the date of the e-mail.

D. Contract Operational Start Date

DHCS may postpone the Contract Operational Start Date for any Contractor that fails to satisfy all Readiness Review requirements. If, for any reason, DHCS does not believe that the Contractor is ready and able to perform its obligations under the Contract prior to the Contract Operational Start Date, DHCS may terminate the Contract. DHCS has the option to, but is not required to, extend the Contract Operational Start Date to allow the Contractor to become ready and able to perform its obligations under the Contract.

8. Authority of DHCS

A. DHCS retains sole authority to establish, define, or determine the reasonableness, necessity, level, and Scope of Work under the program administered through this Contract, or the eligibility of beneficiaries to participate in that program, shall reside with DHCS.

B. DHCS retains sole authority to establish or interpret HCBA Waiver policy, including but not limited to its application related to the above described areas.
1. Comprehensive Care Management Overview

Contractor agrees to provide authorized Comprehensive Care Management services to HCBA Waiver participants according to the HCBA Waiver, available at: http://www.dhcs.ca.gov/services/ltc/Documents/HCB_Alternatives_Waiver_Draft_4_28_17.pdf, and as described herein. Comprehensive Care Management is a collaborative and interdisciplinary approach concentrated on the coordination and monitoring of cost-effective, quality direct care services for individuals enrolled in the HCBA Waiver to meet their complex medical needs and personal goals.

Comprehensive Care Management must be provided to HCBA Waiver participants by a qualified CMT comprised of a Registered Nurse and a Social Worker with at least a Master’s Degree, who are either directly employed by or who subcontract with the Contractor. The CMT works with the participant, the legal representative, and/or the circle of support, to identify and coordinate medically necessary State Plan and Waiver services, in addition to any other non Medi-Cal services potentially available to the participant from across multiple delivery systems, regardless of the funding source, with the goal of maintaining the participant safely in their home and community. However when a waiver participant is enrolled in a Managed Care plan, the plan is responsible for coordinating state plan services for their enrolled members. Therefore, the Waiver Agency should coordinate directly with the plan for the provision of state plan services.

The Contractor receives a tiered per member per month (PMPM) payment for the provision of the Comprehensive Care Management service, based on the acuity of each participant. Only the Contractor is authorized to bill for and provide, and/or subcontract for, the Comprehensive Care Management Waiver service.

2. Services to Be Provided

A. Contractor shall employ, or subcontract with a CMT to provide Comprehensive Care Management services to Waiver participants.

1) The Contractor must ensure their employed/contracted CMTs consist of a Registered Nurse and a Social Worker with at least a Master’s Degree.

2) CMTs are responsible for:

   a. Conducting a comprehensive health and psychosocial assessment of participants’ medical needs, diagnosis, functional and cognitive abilities,
and environmental and social needs, to determine which service(s) are required to meet participants’ needs and preferences in the community.

b. Working with the participants, their legal representatives, circles of support, and primary care physicians to develop goals associated with the participant’s assessed needs, individual circumstances, and preferences.

c. Working with the participants, their legal representatives, circles of support, and primary care physicians to develop a POT to mitigate risk and minimize disruptions in services.

d. Working with the participants, their legal representatives, circles of support to identify when services identified in the POT are available through friends, family, and/or publically funded programs.

e. Working with the participants, their legal representatives, circles of support to implement the POT, which includes identifying service providers and community resources to help assure the timely, effective, and efficient mobilization and allocation of the services.

f. Working with the participants, their legal representatives, and circles of support to identify (and train, if necessary), backup caregivers who are willing and able to provide unpaid support if and when waiver service providers do not arrive when scheduled.

g. Providing information, education, counseling, and advocacy to, and on behalf of, participants.

h. Establishing a care coordination schedule based on the needs and acuity of the participant as determined by their initial service needs assessment and subsequent reassessments.

i. Monitoring the delivery of HCBA Waiver services to ensure participants are receiving services as authorized in their POTs.

j. Monitoring the quality of the authorized services by maintaining ongoing contact with participants (including a monthly face-to-face visit or telephone call) to monitor for changes in health, mood, social integration, functionality, and overall well-being.

k. Conducting annual face-to-face visits, reassessments, and care plan updates; and, following up with the participant after Emergency Department and inpatient facility admissions.
B. Contractor shall ensure Comprehensive Care Management includes the provision of Transitional Case Management and the coordination of any Community Transition services when needed.

1) Transitional Case Management supports participants transitioning from an inpatient setting to a community setting, and may include coordinating services such as housing, equipment, supplies or transportation that may be necessary to leave a health care facility.

2) Coordination of Community Transition Services is organizing and prioritizing non-recurring set-up expenses for individuals who are transitioning from a Medi-Cal licensed health care facility to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses.

C. All costs associated with Case Management, Transitional Case Management and the coordination of Community Transition Services are included in the per member, per month payment for Comprehensive Care Management. For this reason, Case Management, Transitional Case Management, and the coordination of Community Transition Services cannot be billed separately. The participant’s actual community transition costs (e.g., security deposit, set-up fees or deposits for utility or service access, etc.) are billable as separate services.

3. Care Management Team Caseload Thresholds

Contractor shall ensure that Registered Nurses and Social Workers assigned to CMTs do not exceed the caseload thresholds, based on participants’ acuity levels, included in the table below. More detailed descriptions of Waiver participant acuity levels and the Case Management Acuity System are available in sub-provision 4.E..

<table>
<thead>
<tr>
<th>CMT Caseload Thresholds</th>
<th>Registered Nurse</th>
<th>Social Worker</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level 4 - Intensive</strong></td>
<td>Participants at a level 4 acuity must receive face-to-face CMT contact at least once a month and must be reevaluated more frequently than once every 180 days.</td>
<td>1:40</td>
</tr>
<tr>
<td><strong>Level 3 - High</strong></td>
<td>Participants at a level 3 acuity must receive face-to-face CMT contact at least once a month, and must be reevaluated at least once every 180 to 270 days.</td>
<td>1:60</td>
</tr>
<tr>
<td><strong>Level 3 - High</strong></td>
<td>Participants at a level 3 acuity must receive face-to-face CMT contact at least once a month, and must be reevaluated at least once every 180 to 270 days.</td>
<td>1:61</td>
</tr>
<tr>
<td><strong>Level 3 - High</strong></td>
<td>Participants at a level 3 acuity must receive face-to-face CMT contact at least once a month, and must be reevaluated at least once every 180 to 270 days.</td>
<td>1:80</td>
</tr>
</tbody>
</table>
### 4. Comprehensive Care Management Services

A. The Contractor’s CMT shall schedule and complete a face-to-face home visit with the applicant within 60 days of the applicant receiving notification of potential Waiver eligibility.

1) At the face-to-face home visit, the CMT:

   a. Provides the applicant with information about the HCBA Waiver services and provider options.

   b. Completes a comprehensive health and psychosocial assessment of the applicant using the Intake Medical Summary (IMR).

   c. Reviews the Menu of Health Services (MOHS), which is a list of possible service and provider choices, with the applicant.

   d. Completes a home safety evaluation. The home safety evaluation assesses participant accessibility, structural barriers, utilities, evacuation plans, and communication and fire safety systems and devices. Any issues identified should be addressed in the POT.

   e. Completes a person-centered POT to the extent possible.

   f. Determines if Waiver Personal Care Services (WPCS) are medically necessary to maintain the health and safety of the Waiver participant in the community, as well as the number of hours that are required.

B. Contractor’s CMT shall conduct a service needs evaluation using the criteria established in Title 22, California Code of Regulations (CCR), Sections 51173.1, 51120, 51124, 51124.5, 51124.6, 51334 and 51335; Health and Safety Code Section 1250(m); as well as information submitted to support medical necessity for the services as defined in Title 22, CCR §51003.

### Exhibit A – Attachment II
Comprehensive Care Management

| Level 2 - Medium | Participants at a level 2 acuity must receive CMT contact by telephone or face-to-face at least once a month, and must be reevaluated at least once every 270 to 365 days. | 1:81 to 1:100 |
| Level 1 - Low | Participants at a level 1 acuity must receive CMT contact by telephone or face-to-face at least once a month, and must be reevaluated every 365 days. | 1:101 to 1:120 |
Exhibit A – Attachment II
Comprehensive Care Management

1) The CMT must use the IMS / Case Management Record (CMR) forms provided by DHCS for all service needs evaluations and reevaluations to document that participants meet and continue to meet HCBA Waiver medical criteria and eligibility requirements.

2) The CMT must conduct service needs reevaluations at least every 365 days.

3) Within 30 days of the reevaluation, all reevaluation documentation must be completed and made available to DHCS through the MedCompass case management database.

4) The CMT must maintain all documentation to support service needs assessments in the participant's case file in MedCompass.

5) DHCS will review the documentation supporting the comprehensive health and psychosocial assessment and medical necessity and will be responsible for final approval of HCBA Waiver enrollment.

C. At the initial face-to-face home visit and at each of the participant’s reevaluations, the Contractor’s CMT will use the MOHS as a planning tool to assist the participant in making informed choices about the services and providers available.

D. After the Contractor’s CMT has met with the participant to discuss preferences, goals, and desired outcomes, the CMT is responsible for developing a comprehensive POT, which includes:

1) Assisting the applicant with identifying Waiver and State Plan services that will meet the applicant’s medically necessary care needs. Waiver participants enrolled in Managed Care plans are excepted because the plans are responsible for coordinating state plan services for their enrolled members. In these cases, the Waiver Agency should coordinate directly with the plan for the provision of state plan services.

2) Providing information on participant direction, which includes a participant’s right to select and dismiss providers, and on determining the roles and responsibilities of the participant, Contractor, CMT, primary care physician, HCBS service providers, and DHCS.

3) The Contractor’s CMT shall develop a current person-centered POT signed by the current primary care physician and submit the plan to DHCS within 90 days of notifying the participant of his or her eligibility for enrollment in the HCBA Waiver.
a. The POT must include:
   i. Participant’s demographic information
   ii. Treating and current primary care physician’s information
   iii. Medical information and diagnosis
   iv. Care Management Level of Acuity
   v. All medically necessary Waiver services, including the amount, frequency, duration, and Waiver service provider type
   vi. State plan services
   vii. Required durable medical equipment
   viii. Medication plan
   ix. Nutritional requirements
   x. Treatment plan for the home program
   xi. Participant’s functional limitations
   xii. Permitted activities
   xiii. Mental status
   xiv. Medical supplies
   xv. Ongoing therapies and therapy referrals
   xvi. Treatment goals, including rehabilitation potential
   xvii. Training needs for the participant, family member(s), and caregivers
   xviii. Identification of backup caregivers, and their contact information

b. HCBA Waiver participants may choose to be involved in all aspects of the design, delivery, and modification of their services, as well as determining when, where, how, and by whom they receive services. Participants may request a review of their POT at any time.

c. Modifications to the POT can only be made with the approval of the participant or his or her legal representative.

d. If adjustments related to services ordered by the PCP are made to the POT, it must be returned to the PCP for signature.
4) Authorizing WPCS Hours

1) Before including WPCS in a participant’s POT, the CMT must ensure that the participant has been authorized to receive In-Home Support Services (IHSS). If the participant is enrolling in the Waiver from the community, the CMT must contact DHCS’ IHSS/WPCS Unit to verify that the participant is receiving IHSS, and to confirm the number of IHSS hours they have been authorized to receive.

2) After the CMT confirms that the participant is, or is authorized to receive IHSS, the CMT must determine if WPCS hours medically necessary to maintain the participant’s health and safety in the community, as well as the number of hours that are required to do so.

3) Upon determining the number of WPCS hours that are medically necessary to maintain the health and safety of the participant in the community, the CMT must complete and submit a WPCS Authorization Request to DHCS’ IHSS/WPCS Unit to enter the Waiver participant into the California Department of Social Services’ (CDSS’) Case Management, Information and Payrolling System II (CMIPS II).

4) No more than 24 hours of combined IHSS and WPCS hours may be authorized in a single day. No single WPCS provider may be authorized to provide more than 12 hours of WPCS hours in a single day. More detailed information on the Contractor’s responsibilities related to the authorization of WPCS shall be provided to Contractor by DHCS.

E. Case Management Acuity System

1) Contractor’s CMT is responsible for determining the periodicity of reevaluation and the intensity of the required participant case management using the Case Management Acuity System described in Appendix B of the approved HCBA Waiver.

2) The Contractor’s CMT will conduct a home visit to assess the participant’s status 90 days after DHCS approves the participant’s enrollment into the HCBA Waiver and the participant begins receiving Waiver services. The CMT reviews the POT with the participant and/or the legal representative or
established circle of support to verify that services are being provided as described in the POT.

3) The CMT will use the Level of Case Management Acuity system to determine the minimum frequency of home visits based upon the participant’s risk factors and the complexity of their home program. The Case Management Acuity system identifies four levels of case management of increasing acuity. The level of acuity must be reevaluated at each home visit and when there are changes to the participant’s medical care needs, support system, and/or provider types.

4) The Level of Case Management Acuity System is described below:

a. **Level 1** – Participants are medically stable, have not been hospitalized or received emergency care within the previous 12-month period, and have no Medi-Cal eligibility issues or Waiver provider turnover. These participants are to receive CMT contact by telephone or face-to-face on at least a monthly basis and must receive a service needs reevaluation in person through a home visit every 365 days.

b. **Level 2** – Participants have had three or fewer unscheduled hospitalizations and/or visits to the emergency department and/or skilled nursing facility (SNF) stays within the previous 12 month period. Participants may have experienced Waiver provider turnover once or twice, and/or durable medical equipment issues. These participants are to receive CMT contact by telephone or face-to-face on at least a monthly basis and must receive a service needs reevaluation in person through a home visit at least once every 270 to 365 days.

c. **Level 3** – Participants have had four or more unscheduled hospitalizations and/or visits to the emergency department and/or skilled nursing facility (SNF) stays within the previous 12-month period. Participants may have a high turnover of Waiver providers, and/or had difficulty in obtaining the medically necessary services ordered by their current primary care physician. These participants must be evaluated after every hospital and inpatient facility discharge, which must include medication management review. In addition, participants are to have face-to-face CMT contact at
Exhibit A – Attachment II  
Comprehensive Care Management

least once a month, and must receive a service needs reevaluation in person through a home visit at least once every 180 to 270 days.

d. **Level 4** – Participants require frequent monitoring and interventions by the CMT to address issues that affect their health and safety and are at an elevated risk for hospitalization. The CMT conducts frequent on-site visits to work with the participant, legal representative, and/or circle of support and the HCB Waiver providers responsible for rendering Waiver services when there are issues requiring a plan of correction and follow-up. These participants must receive face-to-face CMT contact at least once a month and must be reevaluated after every hospital/SNF discharge and visit to the emergency department. Evaluation is to include medication management review. In addition, participants must receive a service needs reevaluation in person through a home visit more frequently than once every 180 days.

F. Service Needs Reevaluations

1) At each service needs reevaluation, the CMT must ensure the following:

a. Verify the participant’s POT is current and signed by the participant’s current primary care physician. Copies of the current and past POTs are filed in the participant’s case file.

b. Review the POT with the participant, the legal representative, and/or members of their circle of support, and discuss the recommendations for Waiver and non-Waiver services and service providers.

c. Ensure the POT meets the participant’s medically necessary health care needs and personal goals to enable the participant to live safely in the community. During the on-site home visit, the CMT must assess and document if the participant is receiving all the services identified in the POT, whether the participant is satisfied with the care being delivered, and if the participant is receiving the services needed to remain safely at home.

d. Ensure there is a complete and accurate written medical record, including diagnoses, complete evaluation, treatment plan, and prognosis that is
Exhibit A – Attachment II
Comprehensive Care Management

available when determining the medical necessity for the Waiver services described in the POT.

e. Review the back-up plan in the event a provider is not available. The CMT shall assist the participant and the legal representative or members of the circle of support in identifying back-up caregivers and community resources as part of his or her back-up plan.

f. Instruct the participant, the legal representative, and/or circle of support on how to recognize and report abuse, neglect, and exploitation, and document their understanding in writing. The POT should include any risk of abuse, neglect, and exploitation, as well as strategies on how such incidents will be prevented.

g. Ensure the written home safety evaluation has been completed and that all identified issues are addressed in the POT by working with the participant, legal representative, and/or circle of support to remediate identified home safety deficiencies. The home safety evaluation assesses participant accessibility, structural barriers, utilities, evacuation plans, and communication and fire safety systems and devices.

h. Confirm and document that the participant’s home is, or has been made, safe.

i. If the private residence of a prospective Waiver enrollee would pose a risk to the individual’s health or safety, and the residence cannot be made safe, the CMT must not enroll him or her in the Waiver.

ii. If a Waiver participant’s private residence is determined not to be safe, and cannot be made safe, the individual will need to be admitted to an in-patient nursing facility, find an alternative residence in the community, and dis-enroll from the waiver.

i. Document all health and safety issues described in the POT in the CMR and the Event/Issue Report.
Exhibit A – Attachment II
Comprehensive Care Management

G. Provision of Services

1) Contractor’s CMTs shall monitor the provision of all of the HCBA Waiver services included below, and as defined in the Waiver and HCBS Billings Codes and Reimbursement Rates section of the Medi-Cal Providers’ Manual available on the DHCS website.¹

   a. Habilitation
   b. Home Respite
   c. Community Transition Services
   d. Continuing Nursing and Supportive Services
   e. Environmental Accessibility Adaptation
   f. Facility Respite
   g. Family/Caregiver Training
   h. Medical Equipment Operating Expenses
   i. Personal Emergency Response Installation and Testing
   j. PERS Monthly Service
   k. Private Duty Nursing – Including home health aide and shared services
   l. Waiver Personal Care Services

5. Ensure Waiver Participant Rights

A. Person-Centered Planning

1) The CMT shall ensure that the Waiver participant leads the person-centered planning process when possible; even when he or she has a legal representative. The CMT must ensure that the planning process is person-centered as follows:

   a. The planning process includes people chosen by the participant.
   b. The CMT provides necessary information and support to ensure that the participant directs the process to the maximum extent possible, and is enabled to make informed choices and decisions.
   c. The planning process is timely and occurs at times and locations convenient to the participant.

¹ The Medi-Cal Providers’ Manual is available at: http://files.medi-cal.ca.gov/pubsdoco/manuals_menu.asp
Exhibit A – Attachment II
Comprehensive Care Management

d. The planning process reflects cultural considerations of the participant, and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons with limited English proficiency.

e. The planning process includes strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants.

f. The CMT offers informed choices to the participant regarding the services and supports he or she receives and from whom.

g. The planning process includes a method for the participant to request updates to the POT as needed.

h. Records the alternative home and community-based settings that were considered by the participant.

B. Freedom of Choice

1) The CMT shall be responsible for informing Waiver applicants and/or his or her legal representatives of their right to accept or decline Waiver enrollment and Waiver services during the initial evaluation for enrollment in the HCBA Waiver.

2) The CMT shall provide information to the applicant and/or his or her legal representative verbally and in writing with the use of the Informing Notice. The Informing Notice describes the roles and responsibilities of the participant or legally responsible adult, the Contractor, the CMT, Waiver providers, and the applicant’s current primary care physician.

3) The CMT shall send out an Informing Notice to the participant or the legally responsible adult whenever there is a change in Waiver providers.

4) All participants must sign a Freedom of Choice document at the onset of Waiver enrollment before the services are authorized, and/or when the participant denies Waiver services or enrollment.

5) After the CMT conducts the initial evaluation for HCBA Waiver enrollment, it shall send the applicant and/or the legal representative the Informing Notice and the Freedom of Choice form.
6) The Freedom of Choice is the applicant’s signed acknowledgement that the CMT has described the services available under the Waiver, and that the CMT advises the applicant and/or legal representative of the participant’s right to utilize the qualified Waiver service providers of his or her choice.

7) The CMT shall ask the applicant to return the signed and dated Freedom of Choice form within five days of receipt. The CMT may not authorize Waiver services for the applicant until the signed Freedom of Choice is received by the Contractor and is submitted to DHCS as part of a complete application packet.

8) If the signed Freedom of Choice is not received by the Contractor within 30 days of the date the Freedom of Choice was mailed to the applicant, enrollment in the HCBA Waiver will be considered “Declined” and the case will be closed.

9) The CMT must include the signed Freedom of Choice form in the participant’s case file.

C. Circle of Support

The CMT shall assist the participant in identifying and establishing a reliable circle of support to provide ongoing care and support to the participant in the community. Individuals included in a participant’s circle of support are unpaid informal caregivers, and may include family members, legal representative, and any other individual named by the participant.

D. Backup Care Providers

1) The Contractor’s CMT must develop a reliable backup plan for each Waiver participant to ensure the participant’s health and safety are not put at risk in the event that an authorized Waiver service provider does not arrive at the scheduled time.
Exhibit A – Attachment II
Comprehensive Care Management

2) The Contractor’s CMT must ensure back up Waiver service providers are available to provide services in the event that an authorized Waiver service provider does not arrive at the scheduled time.

3) If a Waiver participant’s health or safety is at risk because the Contractor is not able to provide a reliable backup system, the CMT must help the individual return to a facility, find an alternative community residence (e.g. a group-home), and/or dis-enroll from the Waiver.

E. Continuity of Care

1) The Contractor’s CMTs must ensure there are no gaps in participants’ care when an individual:
   a. Transitions onto the Waiver,
   b. Changes providers of authorized services identified in the POT, or
   c. Discharges from a short-term institutionalization.

2) Some of the ways the CMT shall ensure continuity of care include, but are not limited to: appropriate and timely referrals of participants needing specialty health care services, documentation of referral services in participant case records, monitoring participants’ medical appointments, and documentation of participant emergency medical encounters.

F. Safe Home Environment

1) The CMT shall evaluate the safety and accessibility of the applicant’s living environment, and complete a home safety evaluation that it submits to DHCS with the initial Waiver application and service needs evaluation. The CMT must complete and submit to DHCS a new home safety evaluation if the participant changes his or her place of residence.

2) The home safety evaluation must demonstrate that the participant’s home environment is safe and conducive to the successful implementation of a home and community-based services program and include the following:
   a. Assurance that the area where the participant will be cared for can accommodate the use, maintenance, and cleaning of all medical devices and equipment. Assurance that there is sufficient storage for supplies
necessary to safely and comfortably maintain the participant in the home and to facilitate the nursing care required;

b. Assurance that primary and back-up utility, communication, and fire safety systems and devices are available, installed, and in working order, including grounded electrical outlets, smoke detectors, fire extinguisher, and telephone services;

c. Evidence that local emergency and rescue services and utility services have been notified that a person with special needs resides in the home;

d. Assurance that all medical equipment, supplies, primary and back-up systems, and other services and supports, are in place and available in working order, or have been ordered and will be in place at the time the participant is placed in the home;

e. Provide instruction to the participant to ensure they are knowledgeable about how to report and to whom to report abuse, neglect, or exploitation if incidents do occur.

f. Document any discussion and instruction regarding abuse, neglect or exploitation in the participant’s case file.

g. Document that the back-up caregivers are knowledgeable of the care needs of the participant.

G. DHCS Final Review and Approval of Waiver Enrollment

1) Within three business days the Contractor shall notify DHCS that a case file, with all necessary documentation supporting the service needs evaluation, is ready for DHCS review and final approval. No services may be authorized prior to DHCS final approval of an applicant’s eligibility.

2) The Case file must include, but is not limited, to the following:

   a. Waiver Application

   b. Completed health and psychosocial assessment

   c. Completed service needs evaluation based on medical necessity

   d. Home safety evaluation

   e. Completed POT signed by current primary care physician and all Waiver providers
Exhibit A – Attachment II
Comprehensive Care Management

f. Medical documentation supporting medical necessity for authorized services

g. Participant Freedom of Choice signed by participant accepting Waiver services in lieu of facility placement

h. Informing Notice for participant and primary care physician

i. Current MOHS provided to the participant

j. Disclosure Form signed by participant if the Contractor is the only provider of Waiver and Comprehensive Care Management services

k. List of available providers in provider network provided to the participant

l. Service Authorization requests submitted by HCBS service providers

H. Critical Incident Reporting

1) The CMT will act on and document all reported or observed critical events or issues that may affect the health, safety, and/or welfare of the Waiver participant or their service/care providers, as they are discovered.

2) The CMT will use the Event/Issue Report form to document concerns or problems expressed by the participant, their legal representative, service/care providers, and/or circle of support to ensure timely investigation and resolution.

3) The CMT will update the Event/Issue Report form to document the resolution of the event/issue and shall keep it with the participant’s case file.

4) The CMT shall include a description of the identified deficiencies/issues, the plan to address/resolve the deficiency/issues, and the resolution of the deficiency/issues within each Event/Issue Report.

5) The CMT must submit a copy of all Event/Issue Reports to DHCS within 48 hours.

6) The CMT must also report issues of abuse, neglect, or exploitation to the appropriate local or State agencies such as APS, CPS, local law enforcement, CDPH’s L&C, and DHCS, when events or issues are identified that would have a negative impact on the health or safety of a participant.
I. Use of Restraints

If the CMT observes or learns that restraints are being used, the CMT must complete an Event/Issue Report form and submit it to the Contractor, who must then submit it to DHCS. The Event/Issue Report shall document the following, along with the description of the restraints:

1) Whether the use of restraints is ordered by the participant’s current primary care physician.

2) If there is a plan for use and monitoring of restraints in the participant’s POT, and is the plan being followed by caregivers and/or providers.

J. Other Complaints

1) The CMT must respond to verbal complaints verbally. A verbal complaint consists of any expression of dissatisfaction by a participant to the CMT. Verbal complaints are usually resolved within 72 hours. The CMT must document the verbal complaint and resolution in the participant’s case file.

2) A written complaint is considered a formal complaint and consists of any written expression of dissatisfaction by the participant to the CMT. The CMT must submit the report to the Contractor within two business days for documentation and follow-up.
Exhibit A - Attachment III
Service Area Zip Codes

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Exhibit B
Budget Detail and Payment Provisions

1. Invoicing and Payment

A. For HCBA Waiver services satisfactorily rendered to HCBA Waiver participants residing in the Contractor’s service area, DHCS will compensate the service providers in accordance with the HCBA Waiver as follows:

1) **Fee-For-Service Reimbursement for HCBA Waiver Services:** DHCS will pay for HCBA Waiver services (excluding Waiver Personal Care Services, Waiver Administrative services, and Comprehensive Care Management services, which will be paid separately) at the Medi-Cal provider rates published in the current California Medi-Cal Fee Schedule, which is located in the Medi-Cal Provider Manual and can be accessed at [http://files.medi-cal.ca.gov/pubsdoco/Manuals_menu.asp](http://files.medi-cal.ca.gov/pubsdoco/Manuals_menu.asp), as applicable.

   a. Contractor shall authorize requests for services under the HCBA Waiver in accordance with the participant’s Plan of Treatment (POT), medical necessity, and the terms of the Waiver.

   b. To seek payment for Contractor-authorized HCBA Waiver services (other than WPCS, Waiver Administrative services, and Comprehensive Care Management services), The service provider must submit claims on the standardized Medi-Cal billing forms through the approved California Medicaid Management Information System (CA-MMIS), administered by the Medi-Cal fiscal intermediary (FI), using the Contractor’s Medi-Cal number, and identifying the rendering provider and provider number, if applicable, on the submitted claim. If the Contractor is submitting the claims for waiver services on behalf of the service providers, then the Contractor is responsible for reimbursing the service provider at least the fee-for-service rate published in the current California Medi-Cal Fee Schedule, referenced above.

   c. The service provider must only submit claims for HCBA Waiver services identified and described in the HCBA Waiver.

   d. If the Contractor is billing the Medi-Cal FI for the direct Waiver services and reimbursing the direct service providers, then the Contractor must ensure direct service providers are only paid for providing HCBA Waiver services that were pre-authorized by the Contractor’s CMT (in accordance with the participant’s POT, medical necessity, and the terms of the HCBA Waiver), and provided within the authorized period of time.
Exhibit B
Budget Detail and Payment Provisions

e. If the Contractor is billing the Medi-Cal FI for the direct Waiver services and reimbursing the direct service providers, then the Contractor is responsible for ensuring that Waiver services are rendered to the Waiver participant prior to submitting an invoice for payment.

2) **Reimbursement for Waiver Personal Care Services**: Contractor’s CMT determines the number of necessary WPCS hours, if necessary, based on medical necessity and the terms of the HCBA Waiver.

   a. When WPCS are included in a Waiver participant’s authorized POT, the Contractor’s CMT must ensure that the participant has been authorized to receive IHSS by contacting DHCS’ IHSS/WPCS Unit to verify IHSS enrollment and to confirm the number of IHSS hours that have been authorized.

   b. Once the CMT confirms that the Waiver participant is enrolled in IHSS, the CMT completes and submits a WPCS Authorization Letter for DHCS to review and enter the participant’s authorized number of WPCS hours into the CDSS’ CMPIS II.

   c. DHCS will notify the Contractor when the authorized WPCS hours are entered into CMIPS II. Timecards and instructions on how to report the WPCS hours will be mailed to WPCS providers.

3) **Comprehensive Care Management PMPM**: At the end of each month, DHCS will pay the Contractor a tiered PMPM amount for the provision of HCBA Waiver Comprehensive Care Management services to each participant based on monthly enrollment totals using MedCompass enrollment data and participants’ authorized levels of acuity. The amount of the Comprehensive Care Management PMPMs are as follows:

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<thead>
<tr>
<th>Authorized Level of Acuity</th>
<th>Comprehensive Care Management PMPM</th>
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<td>1</td>
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Exhibit B
Budget Detail and Payment Provisions

4) **Waiver Administration PMPM:** At the end of each month, DHCS will pay the Contractor a PMPM in the amount of $186.56 for satisfactorily rendered HCBA Waiver Administration Services based on monthly enrollment totals using MedCompass enrollment data. As described in Exhibit A, Attachment I of this Contract, Waiver Agency administration functions include participant enrollment, service needs evaluations, and person-centered POT review and approval, waiver service authorization, utilization management, provider enrollment/network development, quality assurance activities, billing the DHCS FI, and provider claims adjudication.

2. **Amounts Payable**

A. The amounts payable under this Agreement shall not exceed:

1) $_____ for the budget period of 07/01/2018 through 06/30/2019.

2) $_____ for the budget period of 07/01/2019 through 06/30/2020.

3) $_____ for the budget period of 07/01/2020 through 06/30/2021.

4) $_____ for the budget period of 07/01/2021 through 12/31/2021.

B. Monthly payments shall be made for Administrative and Comprehensive Care Management services, up to the amount annually encumbered commensurate with the state fiscal year in which services are performed.

C. Contractor must maintain records reflecting actual expenditures for each state fiscal year covered by the term of this Agreement.

3. **Budget Contingency Clause**

A. It is mutually agreed that if the Budget Act of the current year or any subsequent years covered under this Contract does not appropriate sufficient funds for the operation of the HCBA Waiver program, the State shall have no liability to pay any funds whatsoever to Contractor or to furnish any other considerations under this Contract for the unfunded or underfunded time span. Further, should funding for any fiscal year of the HCBA Waiver be modified, reduced, or deleted by the Budget Act or by any action of the federal government, the State shall have the option to:

1) Cancel this Contract with no liability occurring to the State, or

2) Offer an amendment to Contractor to reflect the reduced or modified amount.
Exhibit B
Budget Detail and Payment Provisions

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

If this Contract is cancelled or amended as a result of a change in or cancellation of state or federal funding, DHCS will issue guidance to the Contractor regarding the steps to be taken to safely transfer the care of the HCBS participants. Contractor agrees to cooperate with DHCS in performing the safe and timely transition of HCBS participants according to that guidance.

4. Accounting Requirements

Contractor shall establish accounting policies and procedures, maintain records and supply reports as specified in the HCBA Waiver and as requested by DHCS. Accounting policies and practices shall be in accordance with Generally Accepted Accounting Principles (GAAP), CMS federal accounting regulations, and the State Administrative Manual (SAM). The Contractor shall be responsible for establishing and maintaining additional accounting policies, processes, procedures, and records, as required to control and document its fiscal activities. These accounting procedures shall remain the same for the entire Contract period, unless prior written approval of changes is received from the DHCS Contracting Officer.

A. Accounting Procedures Inclusions

The accounting procedures, policies, and records shall include, but not be limited to, the following:

1) Definitions of accounting relationships with other government Contracts, related business organizations, and subcontractors;

2) Procedures for personnel time reporting;

3) A cost accounting system in conformance with Title 48, Code of Federal Regulations, Part 31, which details costs by all contractual categories;

4) Allocation of expenses not totally dedicated to this Contract;

5) Accounting ledgers; and
Exhibit B
Budget Detail and Payment Provisions

6) Allocation (internal and external) methodologies for Cost Reimbursement.

B. Accounting Records Supplied to DHCS

Specific accounting records and practices shall be subject to federal and State acceptance. At DHCS Contracting Officer’s request, the Contractor shall provide DHCS all fiscal records within the timeframe and in the manner requested by DHCS.

5. Supplemental Payment Clause

A. Contractor may enter into agreements with Waiver service providers to pay a negotiated supplemental payment for providing authorized HCBA Waiver services to ensure all Waiver services are available to participants within the Contractor’s service area. Supplemental payments are made in addition to, and do not replace, payments the service providers receive based on the Medi-Cal claiming process through the FI.

6. Expense Allowability / Fiscal Documentation

A. Claims accepted and/or submitted for payment by DHCS shall not be deemed evidence of allowable contract costs.

B. Contractor shall maintain for review and/or audit, and shall supply to DHCS upon request, adequate documentation of all claimed expenses, pursuant to this Contract, to permit a determination of allowable expenses.

C. If DHCS cannot determine whether an expense is allowable or appropriate because the claim detail, fiscal records, or backup documentation is nonexistent or inadequate according to generally accepted accounting principles or practices, DHCS may disallow the expense and withhold payment for that expense. If the Contractor provides adequate documentation supporting a disallowed expense, DHCS may reimburse the amount substantiated and deemed allowable.

D. DHCS may recover from the Contractor any costs and/or expenses paid by DHCS that are later determined to be unallowable.
7. Financial Accountability Review

Contractor must enroll as a Medi-Cal provider and obtain a Medi-Cal provider number. The terms of the Medi-Cal Provider Agreement, the Medi-Cal enrollment application, and all other Medi-Cal enrollment documents apply to the Contractor, in addition to the terms set forth in this Contract.

A. All claims processed through the FI are subject to random post-adjudication, pre-payment verification for detection of errors, irregularities, and potential for waste, fraud, or abuse.

Contractor shall be subject to auditing activities conducted by DHCS and any other entity with authority to audit Medi-Cal claims. This includes, but is not limited to, DHCS accessing Medi-Cal claims data to obtain a random representative sample of all Direct Waiver Service claims, determining if the claims were correctly authorized and billed appropriately.

Based upon DHCS’ findings and the Contractor’s level of compliance, DHCS may, if appropriate, notify the Contractor that the Contractor is required to develop and implement a remediation plan within 30 days. DHCS will evaluate the effectiveness of the Contractor’s remedial actions within 30 days of receipt of the Contractor’s remediation plan and take any appropriate action for the deficiency at issue, including but not limited to termination of this Contract.

DHCS will re-evaluate the Contractor at the next scheduled Quality Assurance Review (QAR). For issues concerning fraud and/or abuse, DHCS refers the issue to its Audits and Investigation Division.

8. This Provision is intentionally left blank

9. Recovery of Overpayments

A. In addition to any recovery authorized or required by law or under the Provider Agreement, DHCS shall have the right to recover amounts paid to Contractor or Waiver service provider in the following circumstances:

1) DHCS determines that a participant has either been improperly enrolled, due to ineligibility of the participant to enroll in the Waiver, the participant resides outside of Contractor's service area, or the participant should have been disenrolled with an effective date in a prior month. DHCS may recover all PMPM payments made to Contractor, as well as any other payments made by DHCS to the Contractor during the period of
Exhibit B
Budget Detail and Payment Provisions

ineligibility.

2) DHCS determines that an erroneous or improper payment has been made for some other reason, including but not limited to the claimed direct Waiver service not actually being provided to the participant, or the claimed direct Waiver service not being medically necessary for the participant.

B. Contractor agrees that Medi-Cal claims of a DHCS overpayment to the Contractor based upon a contractual agreement or an audit finding and/or an audit finding that is appealed and upheld, will be recovered by DHCS. The recovery options include, but are not limited to those set forth in Article 5.3, of Chapter 7, of Part 3, of Division 9, of the Welfare & Institutions Code, such as:

1) Contractor’s payment to DHCS of the full amount of the audit exception within 30 days following DHCS’ request for repayment;

2) A repayment schedule that is agreeable to both DHCS and the Contractor, which could include an offset from future PMPM payments or direct Waiver service claim payments. DHCS reserves the right to select the process for recovering the overpayment that will be employed, and the Contractor will be notified by DHCS in writing of the process to be utilized.

C. If the Contractor files a valid appeal regarding the report of audit findings, recovery of the overpayments will be deferred until a final administrative decision on the appeal has been reached. If the Contractor loses the final administrative appeal, the Contractor shall repay to DHCS the over-claimed or disallowed expenses, plus accrued interest and penalties as set forth in Welfare & Institutions Code section 14171.6.

10. Requirements for Payments of Retroactive Administrative PMPM and Comprehensive Care Management PMPM for Eligible Members

A. Contractor may submit to DHCS a request for payment of retroactive Waiver Administration and Comprehensive Care Management payments for HCBA Waiver participants that continued to receive services offered by the Contractor, but for whom PMPM payments were not made by DHCS due to the member’s eligibility being placed on hold status.
Exhibit B
Budget Detail and Payment Provisions

B. Requests for retroactive PMPM 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. Retroactive PMPM payments are subject to the discretion of DHCS, and will be made only if all of the following conditions have been met:

1) Contractor’s request for retroactive PMPM payments provides adequate and sufficient verifiable documentation for each request, including all information requested by DHCS;

2) Enrollment in the Waiver has been verified through the Medi-Cal Eligibility Data System (MEDS) for each month retroactive PMPM payments are being requested;

3) During the period for which Contractor is requesting retroactive PMPM payments, the Contractor has continued to satisfactorily demonstrate that it reconciles and reports eligibility for all members on a monthly basis;

4) The request for retroactive payments for participants with a previous unmet share of cost has been reconciled and submitted on a monthly basis; and

5) Contractor is, in DHCS’ determination, in substantial compliance with all contractual requirements at the time a request for retroactive payment is made.

C. Retroactive payment requests shall be made within 30 days from the end of the month during which the member for whom retroactive payments are being requested has had their eligibility status removed from hold status. Under no circumstances will DHCS consider retroactive payment requests more than six months from the time the member’s eligibility status has been restored.

D. All decisions by DHCS with respect to approval or denial of a request for retroactive payments shall be final.

E. Contractor may be required to submit documentation to DHCS, which may include, but is not limited to the following:

1) Medi-Cal Eligibility Verification from MedCompass that indicates Medi-Cal eligibility has been restored and/or Notice of Action issued from the County for the requested month(s) of retroactive reimbursement;
Exhibit B
Budget Detail and Payment Provisions

2) Letter from the County in which the member resides to verify the participant’s residence and date of residency; and

3) Monthly share of cost for the requested month(s) of retroactive payments, with the member’s name and share of cost amount highlighted.

F. For the purpose of processing retroactive requests, DHCS shall have available and shall provide to Contractor upon request, a form for the Contractor to use when submitting all required member information to DHCS to review in support of Contractor’s request for retroactive reimbursement.

G. DHCS may require the Contractor to perform a time study to support the PMPM payments.
1. Additional Incorporated Exhibits

The following documents and any subsequent updates are not attached, but are incorporated herein and made a part hereof by this reference. The Contractor is required to fully comply with the directives in each document incorporated by reference herein and each update thereto. These documents may be updated periodically by DHCS, as required by program directives, or changes in law or policy. Unless otherwise indicated, DHCS shall provide the Contractor with copies of the listed documents at the time, or before the Contract is presented to the Contractor for review, acceptance, and signature. Periodic updates to the below listed documents that are not electronically accessible via the Internet, an Extranet link or other mechanism will be presented to the Contractor under separate cover and acknowledgement of receipt will be required. DHCS will maintain on file, all documents referenced herein and any subsequent updates.

A. The California’s State Medicaid Plan and Approved State Plan Amendments; available online at:
   http://www.dhcs.ca.gov/formsandpubs/laws/Pages/SPdocs.aspx, and
   http://www.dhcs.ca.gov/formsandpubs/laws/Pages/RecentAmendments.aspx

B. The HCBA Waiver, available at:
   http://www.dhcs.ca.gov/services/ltc/Pages/Home-and-Community-Based-(HCB)-Alternatives-Waiver.aspx

C. The HCBA Waiver Manual, available at:
   http://www.dhcs.ca.gov/services/ltc/Pages/Home-and-Community-Based-(HCB)-Alternatives-Waiver.aspx

D. Policy and Guidance Letters issued by DHCS to Contractors; available online at: http://www.dhcs.ca.gov/services/ltc/Pages/Home-and-Community-Based-(HCB)-Alternatives-Waiver.aspx


F. The Medi-Cal Statewide Transition Plan, available online at:
   http://www.dhcs.ca.gov/services/ltc/Pages/HCBSStatewideTransitionPlan.aspx
Exhibit E
Additional Provisions

G. The Medi-Cal Provider Application, available online at:
   http://files.medi-cal.ca.gov/pubsdoco/Publications/masters-other/provappsenroll/02enrollment_DHCS6208.pdf

H. Contractor’s Solicitation for Application (SFA)

I. Operational Start Date Authorization Notice, which shall serve as DHCS’ official, written notification that the Contractor has successfully completed all Readiness Deliverables, and is authorized to provide Comprehensive Care Management services to HCBA participants.

2. Term of the Contract

   A. The term of the Contract will be of no force or effect until it is approved by DHCS and signed by both parties. The Contract shall become effective July 1, 2018 and shall continue in full force and effect through December 31, 2021, with two optional extensions of one year each at the discretion of DHCS. The Contractor is advised not to commence performance until all approvals have been obtained. Should the Contractor commence performance before all approvals are obtained, services rendered prior to all approvals being obtained will be considered to have been volunteered by both the Contractor and any of its employees or subcontractors.

   B. The Contract term may change if the Department makes a selection earlier than expected or if the Department cannot execute the contract in a timely manner due to unforeseen delays. DHCS reserves the right to extend the term of the resulting contract via an amendment as necessary to complete or continue the services. Contract extensions are subject to satisfactory performance, funding availability, and approval by DHCS.

3. Amendment Process

   Should either party, during the term of this Contract, desire a change or amendment to the terms of this Contract, 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 the changes or amendments are accepted, the agreed upon changes or amendments shall be made through DHCS’s official contract amendment process, unless otherwise stipulated within this Contract. No amendment will be considered binding on either
Exhibit E
Additional Provisions

party until it is formally approved and signed by both parties.

4. Cancelation/Termination

A. This Contract may be cancelled or terminated without cause by either party by giving advance written notice to the other party subject to the termination requirements set forth below. Such notification shall state the effective date of termination or cancellation and include any final performance and/or payment/invoicing instructions/requirements.

B. Upon receipt of a notice of termination or cancellation from DHCS, Contractor shall take immediate steps to stop enrolling new HCBA Waiver participants and to cancel or reduce subsequent contract costs.

C. The Contractor shall be entitled to payment for all allowable costs authorized under this Contract 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. Notice of Termination

A. If state or federal Medicaid funding is reduced or deleted prior to the end date of this Contract, DHCS shall have the option to terminate this Contract.

B. Termination without Cause

1) DHCS may terminate performance of work under this Contract, in whole or in part, without cause if the Department determines that a termination is in the State’s interest. DHCS shall terminate by delivering to the Contractor a Notice of Termination specifying the extent of termination and the effective date thereof. Such termination shall be effective 30 days from the delivery of the Notice of Termination unless DHCS determines that immediate termination is necessary to protect the health or safety of Medi-Cal members.

2) After receipt of a Notice of Termination, and except as directed by DHCS, the Contractor shall immediately proceed with the following obligations, as applicable, regardless of any delay in determining or adjusting reimbursements. The Contractor shall:

   a) Stop work as specified in the Notice of Termination;
**Exhibit E**  
Additional Provisions

b) Terminate all subcontracts to the extent they relate to the work terminated; and

c) Submit a transition plan as specified in Provision 9, subparagraph F of this Exhibit.

C. Termination for Cause

1) DHCS may, by written Notice of Termination to the Contractor, terminate this Contract, in whole or in part, as a consequence of any of the following events:

   a) In case of threat of life, health, or safety of the public (termination of Contract shall be effective immediately);

   b) A violation of the law or failure to comply with any condition of this Contract;

   c) Inadequate performance or failure to make progress so as to endanger performance of this Contract;

   d) Failure to comply with reporting requirements;

   e) Evidence that the Contractor is in an unsatisfactory financial condition as determined by DHCS or evidence of a financial condition that endangers performance of this Contract;

   f) Delinquency in payment of taxes or payment of costs for performance of this Contract in the ordinary course of business;

   g) Appointment of a trustee, receiver, or liquidator for all or a substantial part of the Contractor’s property, or institution of bankruptcy, reorganization or the arrangement of liquidation proceedings by or against the Contractor;

   h) Service of any writ of attachment, levy of execution, or commencement of garnishment proceedings against the Contractor’s assets or income;

   i) The commission of an act of bankruptcy;

   j) Finding of debarment or suspension; or


Exhibit E
Additional Provisions

k) The Contractor’s organizational structure has materially changed.

2) Termination of this Contract shall take effect immediately in the case of a threat to life, health, or safety of the public; or in all other cases listed above, upon 30 days subsequent to written notice to the Contractor.

3) The Notice of Termination shall describe the action being taken, the date of termination, the reason for such action, and any conditions of the termination. The Notice of Termination shall also include the requirement to submit a transition plan, as identified in subparagraph F. of this Exhibit; and will inform the Contractor of any right to appeal such decision to DHCS and of the procedure for doing so.

D. Notice of Intent to Terminate by Contractor

The Contractor shall give DHCS written Notice of Intent to Terminate at least 180 days prior to the proposed effective date of termination. The notice shall include the reason for such action and the anticipated last day of work. Upon receipt of such notice, DHCS will work with the Contractor to develop a Transition Plan and terminate the Contract.

Without such notice, the Contractor does not have the authority to terminate the contract.

E. Contractor Obligations upon Notice of Termination

1) In the event of termination or anticipated termination of this Contract, in full or in part, the Contractor shall take immediate steps to ensure the health and welfare of Waiver participants served by the Contractor, until a new service provider(s) is/are able to assume responsibility to provide services to Waiver participants.

2) To maintain the continuity of services provided to Waiver participants in the event of termination or anticipated termination of this Contract, the Contractor shall:

   a) Develop a written Transition Plan, with assistance from DHCS, to identify alternative services for each Waiver Participant;

   b) Cooperate with any and all efforts to refer Waiver Participants to other service providers;
Exhibit E
Additional Provisions

c) Provide DHCS, and anyone else designated by DHCS, with copies of Waiver Participants’ files and other pertinent information necessary for the provision of efficient follow up, continuity of care and transition coordination services by another service provider, in either electronic form, paper form, or both as requested by DHCS, within five working days of the Notice of Termination; and

d) Maintain sufficient staff to provide services during the course of transitioning Waiver participants to another service provider(s).

F. Transition Plan

1) The Contractor shall submit a written transition plan to DHCS within 15 days of delivery of the Notice to Terminate the Contract. The transition plan must be approved by DHCS and shall, at a minimum, include the following:

a) Current count of Waiver participants, their identifying information, and their current contact information;

b) Description of how Waiver participants will be notified about the change in their service provider(s);

c) Plan to communicate with other service providers and advocacy organizations that can assist in locating alternative services;

d) Plan to inform community referral sources of the pending termination of this Contract and what alternatives, if any, exist for future referrals;

e) Plan to transfer confidential Waiver participant files to a new Contractor, and/or DHCS;

f) Plan for sufficient staff to serve the Waiver participants during the course of transitioning them to another service provider(s); and

g) Additional information, as necessary, to ensure a safe transition of Waiver participants to another service provider(s).

2) The Contractor shall implement the Transition Plan as approved by DHCS. DHCS shall monitor the Contractor’s progress in carrying out all elements of the Transition Plan.
6. **Subcontract Requirements**

A. This provision replaces and supersedes provision 5 of Exhibit D(F).

B. The Contractor may elect to enter into subcontracts with other entities to fulfill the obligations of the contract, excluding the provision of Administrative services, as described in Exhibit A, Attachment I, and Comprehensive Care Management services, as described in Exhibit A, Attachment II, which must be provided by the Contractor. In doing so, the Contractor shall meet the subcontracting requirements outlined in this contract.

C. Each Subcontract shall contain:

1) Specification of the services to be provided by the Subcontractor.

2) Specification that the subcontract shall be governed by and construed in accordance with all state and federal laws and applicable regulations governing this contract and the provision of services under the HCBA Waiver.

3) Specification of the term of the subcontract, including the beginning and ending dates as well as methods of extension, renegotiation, and termination.

4) Subcontractor’s agreement to submit reports as required by the Contractor.

5) Subcontractor's agreement to make all of its books and records pertaining to the goods and services furnished under the terms of the subcontract, available for inspection, examination, or copying:

   a) By DHCS, the California Department of Justice (DOJ), the United States Department of Justice, the California Bureau of State Audits, the Center for Medicare and Medicaid Services (CMS), and anyone else acting on their behalf;

   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) Comply with generally accepted accounting principles; and

   e) For a term of at least three years from the close of DHCS’ fiscal year in
Exhibit E
Additional Provisions

which the subcontract was in effect;

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

7) Subcontractor’s agreement to hold harmless both the State and its members in the event the Contractor cannot or shall not pay for services performed by the Subcontractor pursuant to the Subcontract.

8) Subcontractor’s agreement to allow DHCS to perform onsite inspections at any time with respect to the services and payment for Medi-Cal beneficiaries, and to provide DHCS with copies (hardcopy and/or electronic) of all records upon request.

9) Subcontractor’s agreement to follow the statutes and regulations governing the Medi-Cal program.

10) Subcontractor’s agreement to cooperate with the contractor in any transition plan following notice of termination of the waiver.

D. Public Records and Requests for Records

1) Subcontracts entered into by the Contractor and all information received in accordance with this subsection will be public records on file with DHCS, except as specifically exempted by statute or other legal authority. 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.

2) If a Contractor or any of its subcontractors receive a request for public records or a subpoena for records related to the HCBA Waiver, including but not limited to information regarding enrollees, the Contractor or its subcontractor shall deliver the request or subpoena to DHCS so that it is received by DHCS no later than one business day after it is received by the Contractor or its subcontractor. The Contractor and its subcontractors must cooperate with DHCS in evaluating and preparing any response necessary to respond to the request or subpoena.

7. Access to Records and Record Retention

A. This provision replaces and supersedes provision 7 of Exhibit D(F).
Exhibit E
Additional Provisions

B. The Contractor and any subcontractors shall maintain electronic and/or paper books, records, documents, and other evidence of service performance, procedures, and practices sufficient to reflect all requirements related to performance of this contract. The foregoing constitutes “records” for the purpose of this provision.

C. The Contractor and any subcontractor shall fulfill Waiver participants’, or their legal representatives’, requests for copies of the participants’ record(s) within 30 days of the request.

D. The Contractor agrees that CMS, DHCS, the California Department of General Services, the California Bureau of State Audits, the United States Department of Justice, or their designated representatives shall have the right to review and to copy any records and supporting documentation pertaining to the performance of this contract. The Contractor agrees to allow the auditor(s) access to review and copy such records during normal business hours and to allow interviews of any employees who might reasonably have information related to such records. Further, the Contractor agrees to include a similar right of DHCS to audit records and interview staff concerning any subcontract related to performance of this Contract. (GC 8546.7, CCR Title 2, Section 1896).

E. The Contractor shall make all administrative, general program, and fiscal records available to representatives of DHCS, State Controller’s Office, CMS, the United States Department of Justice, and other authorized state or federal representatives designated by federal CMS regulations/statutes, during normal business hours, for the purpose of inspecting, auditing, and/or photocopying such records. The Contractor is required to promptly transmit to DHCS, all requests for administrative, general program, and fiscal records, in either hard copy or electronic format.

F. The Contractor shall comply with the above requirements and, by signing this Contract, is deemed to be aware of the penalties for violations of law such as fraud and for obstruction of investigation as set forth in Public Contract Code § 10115.10, if applicable.

G. Participant records are to be kept onsite at the Contractor’s established place of business as long as the case is open and active. Following termination of
this contract, participant records will be maintained onsite at the Contractor’s established place of business for a period of three years following the year of case closure, or for a longer period if deemed necessary by DHCS. A longer period of retention may be established by the Contractor. After the authorized period has expired, confidential records shall be shredded and disposed of in a manner that will maintain confidentiality.

H. The Contractor may, at its discretion, following the last day included within the term of this contract, reduce its accounts, books and records related to this contract to microfilm, computer disk, CD ROM, or other data storage medium. Upon request by an authorized representative to inspect, audit or obtain copies of said records, the Contractor must supply or make available applicable devices, hardware, and/or software necessary to view, copy and/or print said records. Applicable devices may include, but are not limited to, microfilm readers and microfilm printers, etc.

8. Avoidance of Conflicts of Interest by Contractor

A. DHCS intends to avoid any real or apparent conflict of interest on the part of the Contractor, subcontractors, or employees, officers, or directors of the Contractor. Thus, DHCS reserves the right to determine, at its sole discretion, whether any information, assertion or claim received from any source indicates the existence of a real or apparent conflict of interest.

B. DHCS’ determination of a suspected or potential conflict of interest will be based on all the proposed contractor’s business affiliations and contractual relationships.

C. If a conflict of interest is determined to exist by DHCS and cannot be resolved to the satisfaction of DHCS, before or after the award or the contract, the conflict will be grounds for the proposal to be deemed nonresponsive and/or termination of the contract.

D. A contract shall not be approved or renewed by the Department if any state officer or state employee, his or her spouse or child has a substantial financial interest in 1), 2) or 3) below. For the purposes of this subsection, state employee includes any Department employee in an analyst, auditor or medical personnel classification who has direct responsibility for the negotiation,
development or management of a medical services or case management contract.

1) The contract or the contracting organization.

2) Any contract with the contracting organization.

3) Procurement of a contract for the contracting organization.

E. A contract shall not be approved or renewed if a state officer or state employee provides legal or management services to the contracting organization. A state officer or state employee shall not share in the income or any remuneration derived from the provision of legal or management services to a contracting organization.

F. A contract shall not be approved or renewed if any state officer or state employee receives anything of value for the purpose of influencing or attempting to influence the negotiations for approval or renewal of the contract.

G. Contractor shall not contract with any subcontractor if any of the following persons connected with Contractor have a substantial financial interest in the subcontractor:

1) Any person also having a substantial financial interest in the subcontractor.

2) Any director, officer, partner, trustee or employee of the subcontractor.

3) Any member of the immediate family of any person designated in 1) or 2).

9. Dispute Resolution

A. This provision replaces and supersedes provision 15 of Exhibit D(F).

B. A Contractor grievance exists whenever there is a dispute arising from DHCS’ action in the administration of this Contract. If there is a dispute or grievance between the Contractor and DHCS, the Contractor must seek resolution using the procedure outlined below:

1) Filing a dispute will not preclude DHCS from recouping the value of the amount in dispute from the Contractor or from offsetting this amount from subsequent reimbursements until it is fully recouped.
2) DHCS and Contractor agree to try to resolve all contractual issues by negotiation and mutual agreement at the State Program Contract Manager level without litigation. The parties recognize that the implementation of this policy depends on cooperation and the need for both sides to present adequate supporting information on matters in question.

3) Within 15 calendar days of the date of the dispute concerning performance of this Contract arises or otherwise becomes known to the Contractor, the Contractor will notify the State Program Contract Manager in writing of the dispute by submitting a Notification of Dispute, describing the conduct (including actions, inactions, and written or oral communications) which it is disputing. The Contractor's Notification of Dispute will state, on the basis of the most accurate information then available to the Contractor, the following:

a) That it is a dispute pursuant to this section;

b) The date, nature, and circumstances of the conduct which is subject of the dispute;

c) The names, phone numbers, function, and activity of each Contractor, subcontractor, DHCS/State official or employee involved in or knowledgeable about the dispute;

d) The identification of any documents and the substances of any oral communications involved in the dispute. Copies of all identified documents will be attached;

e) The reason the Contractor is disputing the conduct;

f) The cost impact to the Contractor directly attributable to the alleged disputed conduct, if any; and

g) The Contractor's desired remedy.

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

D. Following submission of the required notification and supporting
Exhibit E
Additional Provisions

documentation, the Contractor will diligently comply with the requirements of this contract, including matters identified in the Notification of Dispute.

E. Pursuant to a request by the Contractor, the State Program Contract Manager may provide for a dispute to be decided by an alternate dispute officer designated by DHCS, who is not the State Program Contract Manager and who is not directly involved with the Waiver program. Any disputes concerning performance of this Contract shall be decided by the State Program Contract Manager or the alternate dispute officer in a written decision stating the factual basis for the decision. Within 30 calendar days of receipt of a Notification of Dispute, the State Program Contract Manager or the alternate dispute officer, shall either:

1) Find in favor of Contractor, in which case the State Program Contract Manager or alternate dispute officer may:
   a) Countermand the earlier conduct which caused Contractor to file a dispute; or
   b) Reaffirm the conduct and direct DHCS to comply; 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 the Contractor's notification is inadequate to permit a decision to be made under 1) or 2) above, and shall advise the Contractor as to what additional information is required, and establish how that information shall be furnished. The Contractor shall have 30 calendar days to respond to the State Program Contract Manager's or alternate dispute officer's request for further information. Upon receipt of this additional, requested information, the State Program Contract Manager or alternate dispute officer shall have 30 calendar days to respond with a decision. Failure to supply additional information required by the State Program Contract Manager or alternate dispute officer within the time period specified above shall constitute a waiver by the Contractor of all claims.

F. A copy of the decision shall be served to the Contractor.

G. Appeal of State Program Contract Manager's or Alternate Dispute Officer's
Exhibit E
Additional Provisions

Decision

1) Contractor shall have 30 calendar days following the receipt of the decision to file an appeal of the decision to the Director. All appeals shall be governed by Health and Safety Code Section 100171, except for those provisions of Section 100171(d)(1) relating to accusations, statements of issues, statement to respondent, and notice of defense. All appeals shall be in writing and shall be filed with DHCS' Office of Administrative Hearings and Appeals. An appeal shall be deemed filed on the date it is received by the Office of Administrative Hearings and Appeals. An appeal shall specifically set forth each issue in dispute, and include Contractor's contentions as to those issues. However, Contractor's appeal shall be limited to those issues raised in its Notification of Dispute filed pursuant to Paragraph A(3) above. Failure to timely appeal the decision shall constitute a waiver by the Contractor of all claims arising out of that conduct, the Contractor shall exhaust all procedures provided for in this Provision 9, Dispute Resolution, prior to initiating any other action to enforce this Contract.

2) Contractor’s Duty to Perform; pending final determination of any dispute hereunder, the Contractor shall perform according to the terms of this Contract, and in accordance with the State Program Contract Manager's or alternate dispute officer's decision.

3) If pursuant to an appeal under Paragraph B. Appeal of State Program Contract Manager’s or Alternate Dispute Officer’s Decision above, the State Program Contract Manager's or alternate dispute officer’s decision is reversed, the effect of the decision pursuant to Paragraph B. shall be retroactive to the date of the State Program Contract Manager’s or alternate dispute officer’s decision, and the Contractor shall promptly receive any benefits of such decision. DHCS shall not pay interest on any amounts paid pursuant to a State Program Contract Manager's or alternate dispute officer's decision or any appeal of such decision.

10. Insurance Requirements

A. General Liability Insurance - Government Entities and Nonprofit Organizations must obtain Proof of Insurance that shall comply with the
Exhibit E
Additional Provisions

following insurance requirements:

1) The Contractor must furnish to DHCS a certificate of insurance stating that commercial general liability insurance of not less than $1,000,000 per occurrence for bodily injury and property damage liability combined is presently in effect for the Contractor. The commercial general liability insurance policy shall include coverage for liabilities arising out of premises, operations, independent contractors, products, completed operations, personal and advertising injury, and liability assumed under an insured agreement. The commercial general liability insurance shall apply separately to each insured against whom claim is made or suit is brought subject to the Contractor’s limit of liability.

2) The certificate of insurance must identify the contract number for which the certificate of insurance applies and include the following provisions:

   a) The insurer will not cancel the insured’s coverage without giving 30 days prior written notice to DHCS, and

   b) The State of California, its officers, agents, employees, and servants are included as additional insureds, but only with respect to work performed for the State of California under this contract.

B. Automobile Liability Insurance - The Contractor shall maintain motor vehicle liability with limits of not less than $1,000,000 per accident. Such insurance shall cover liability arising out of a motor vehicle including owned, hired, and non-owned motor vehicles being used to provide Waiver services, or to comply with requirements included under this contract.

C. Appropriate Professional Liability Insurance - The Contractor shall maintain appropriate professional liability insurance of not less than $1,000,000 as it appropriately relates to the services rendered under this contract. Coverage shall include errors and omissions.

D. The Contractor agrees that the insurance required herein will remain in effect at all times during the term of the contract. In the event said insurance coverage expires or is terminated at any time or times during the term of this contract, the Contractor agrees to provide, at least 30 calendar days before said expiration
date, a new certificate of insurance evidencing insurance coverage as provided for herein for not less than the remainder of the term of the contract or for a period of not less than one year. DHCS may, in addition to any other remedies it may have, terminate this contract on the occurrence of such event.

E. DHCS will not be responsible for any premiums, deductibles, or assessments on the insurance policy.

11. Contractor Notification of Financial Related Events to DHCS

A. The Contractor must notify DHCS in writing of any of the following events within five business days of their occurrence:

1) Delinquency in payment of taxes or payment of costs for performance of this Contract in the ordinary course of business;

2) Appointment of a trustee, receiver, or liquidator for all or a substantial part of the Contractor’s property, or institution of bankruptcy, reorganization or the arrangement of liquidation proceedings by or against the Contractor;

3) Service of any writ of attachment, levy of execution, or commencement of garnishment proceedings against the Contractor’s assets or income;

4) The commission of an act of bankruptcy;

5) Finding of debarment or suspension; or

6) The Contractor’s organizational structure has materially changed.

12. Federal Oversight Requirements

The Contractor and their subcontractors are considered contractors solely for the purposes of 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). Consequently, as a contractor, as distinguished from sub-recipient, a Dun and Bradstreet Universal Numbering System (DUNS) number is not required.
I. Recitals

A. This Contract (Agreement) has been determined to constitute a business associate relationship under the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (“HIPAA”), the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 (“the HITECH Act”), 42 U.S.C. section 17921 et seq., and their implementing privacy and security regulations at 45 CFR Parts 160 and 164 (“the HIPAA regulations”).

B. The Department of Health Care Services (“DHCS”) wishes to disclose to Business Associate certain information pursuant to the terms of this Agreement, some of which may constitute Protected Health Information (“PHI”), including protected health information in electronic media (“ePHI”), under federal law, and personal information (“PI”) under state law.

C. As set forth in this Agreement, Contractor, here and after, is the Business Associate of DHCS acting on DHCS’ behalf and provides services, arranges, performs or assists in the performance of functions or activities on behalf of DHCS and creates, receives, maintains, transmits, uses or discloses PHI and PI. DHCS and Business Associate are each a party to this Agreement and are collectively referred to as the "parties."

D. The purpose of this Addendum is to protect the privacy and security of the PHI and PI that may be created, received, maintained, transmitted, used or disclosed pursuant to this Agreement, and to comply with certain standards and requirements of HIPAA, the HITECH Act and the HIPAA regulations, including, but not limited to, the requirement that DHCS must enter into a contract containing specific requirements with Contractor prior to the disclosure of PHI to Contractor, as set forth in 45 CFR Parts 160 and 164 and the HITECH Act, and the Final Omnibus Rule as well as the Alcohol and Drug Abuse patient records confidentiality law 42 CFR Part 2, and any other applicable state or federal law or regulation. 42 CFR section 2.1(b)(2)(B) allows for the disclosure of such records to qualified personnel for the purpose of conducting management or financial audits, or program evaluation. 42 CFR Section 2.53(d) provides that patient identifying information disclosed under this section may be disclosed only back to the program from which it was obtained and used only to carry out an audit or evaluation purpose or to investigate or prosecute criminal or other activities, as authorized by an appropriate court order.

E. The terms used in this Addendum, but not otherwise defined, shall have the same meanings as those terms have in the HIPAA regulations. Any reference to statutory or regulatory language shall be to such language as in effect or as amended.

II. Definitions

A. Breach shall have the meaning given to such term under HIPAA, the HITECH Act, the HIPAA regulations, and the Final Omnibus Rule.

B. Business Associate shall have the meaning given to such term under HIPAA, the HITECH Act, the HIPAA regulations, and the final Omnibus Rule.

C. Covered Entity shall have the meaning given to such term under HIPAA, the HITECH Act, the HIPAA regulations, and Final Omnibus Rule.

D. Electronic Health Record shall have the meaning given to such term in the HITECH Act, including, but not limited to, 42 U.S.C Section 17921 and implementing regulations.
E. Electronic Protected Health Information (ePHI) means individually identifiable health information transmitted by electronic media or maintained in electronic media, including but not limited to electronic media as set forth under 45 CFR section 160.103.

F. Individually Identifiable Health Information means health information, including demographic information collected from an individual, that is created or received by a health care provider, health plan, employer or health care clearinghouse, and relates to the past, present or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, that identifies the individual or where there is a reasonable basis to believe the information can be used to identify the individual, as set forth under 45 CFR section 160.103.

G. Privacy Rule shall mean the HIPAA Regulation that is found at 45 CFR Parts 160 and 164.

H. Personal Information shall have the meaning given to such term in California Civil Code section 1798.29.

I. Protected Health Information means individually identifiable health information that is transmitted by electronic media, maintained in electronic media, or is transmitted or maintained in any other form or medium, as set forth under 45 CFR section 160.103.

J. Required by law, as set forth under 45 CFR section 164.103, means a mandate contained in law that compels an entity to make a use or disclosure of PHI that is enforceable in a court of law. This includes, but is not limited to, court orders and court-ordered warrants, subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or an administrative body authorized to require the production of information, and a civil or an authorized investigative demand. It also includes Medicare conditions of participation with respect to health care providers participating in the program, and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits.

K. Secretary means the Secretary of the U.S. Department of Health and Human Services ("HHS") or the Secretary's designee.

L. Security Incident means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of PHI or PI, or confidential data that is essential to the ongoing operation of the Business Associate’s organization and intended for internal use; or interference with system operations in an information system.

M. Security Rule shall mean the HIPAA regulation that is found at 45 CFR Parts 160 and 164.

N. Unsecured PHI shall have the meaning given to such term under the HITECH Act, 42 U.S.C. section 17932(h), any guidance issued pursuant to such Act, and the HIPAA regulations.

III. Terms of Agreement

A. Permitted Uses and Disclosures of PHI by Business Associate

Permitted Uses and Disclosures. Except as otherwise indicated in this Addendum, Business Associate may use or disclose PHI only to perform functions, activities or services specified in this Agreement, for, or on behalf of DHCS, provided that such use or disclosure would not violate the HIPAA regulations, if done by DHCS. Any such use or disclosure must, to the extent practicable, be limited to the limited data set, as defined in 45 CFR section 164.514(e)(2), or, if needed, to the minimum necessary to accomplish
Exhibit F
HIPAA Business Associate Addendum

the intended purpose of such use or disclosure, in compliance with the HITECH Act and any guidance issued pursuant to such Act, the HIPAA regulations, the Final Omnibus Rule and 42 CFR Part 2.

1. **Specific Use and Disclosure Provisions.** Except as otherwise indicated in this Addendum, Business Associate may:
   
   a. **Use and disclose for management and administration.** Use and disclose PHI for the proper management and administration of the Business Associate provided that such disclosures are required by law, or the Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and will be used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware that the confidentiality of the information has been breached.

   b. **Provision of Data Aggregation Services.** Use PHI to provide data aggregation services to DHCS. Data aggregation means the combining of PHI created or received by the Business Associate on behalf of DHCS with PHI received by the Business Associate in its capacity as the Business Associate of another covered entity, to permit data analyses that relate to the health care operations of DHCS.

B. Prohibited Uses and Disclosures

1. Business Associate shall not disclose PHI about an individual to a health plan for payment or health care operations purposes if the PHI pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full and the individual requests such restriction, in accordance with 42 U.S.C. section 17935(a) and 45 CFR section 164.522(a).

2. Business Associate shall not directly or indirectly receive remuneration in exchange for PHI, except with the prior written consent of DHCS and as permitted by 42 U.S.C. section 17935(d)(2).

C. Responsibilities of Business Associate

Business Associate agrees:

1. **Nondisclosure.** Not to use or disclose Protected Health Information (PHI) other than as permitted or required by this Agreement or as required by law.

2. **Safeguards.** To implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI, including electronic PHI, that it creates, receives, maintains, uses or transmits on behalf of DHCS, in compliance with 45 CFR sections 164.308, 164.310 and 164.312, and to prevent use or disclosure of PHI other than as provided for by this Agreement. Business Associate shall implement reasonable and appropriate policies and procedures to comply with the standards, implementation specifications and other requirements of 45 CFR section 164, subpart C, in compliance with 45 CFR section 164.316. Business Associate shall develop and maintain a written information privacy and security program that includes administrative, technical and physical safeguards appropriate to the size and complexity of the Business Associate’s operations and the nature and scope of its activities, and which incorporates the requirements of section 3, Security, below. Business Associate will provide DHCS with its current and updated policies.
3. **Security.** To take any and all steps necessary to ensure the continuous security of all computerized data systems containing PHI and/or PI, and to protect paper documents containing PHI and/or PI. These steps shall include, at a minimum:

   a. Complying with all of the data system security precautions listed in Attachment A, the Business Associate Data Security Requirements;

   b. Achieving and maintaining compliance with the HIPAA Security Rule (45 CFR Parts 160 and 164), as necessary in conducting operations on behalf of DHCS under this Agreement;

   c. Providing a level and scope of security that is at least comparable to the level and scope of security established by the Office of Management and Budget in OMB Circular No. A-130, Appendix III - Security of Federal Automated Information Systems, which sets forth guidelines for automated information systems in Federal agencies; and

   d. In case of a conflict between any of the security standards contained in any of these enumerated sources of security standards, the most stringent shall apply. The most stringent means that safeguard which provides the highest level of protection to PHI from unauthorized disclosure. Further, Business Associate must comply with changes to these standards that occur after the effective date of this Agreement.

Business Associate shall designate a Security Officer to oversee its data security program who shall be responsible for carrying out the requirements of this section and for communicating on security matters with DHCS.

D. **Mitigation of Harmful Effects.** To mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate or its subcontractors in violation of the requirements of this Addendum.

E. **Business Associate’s Agents and Subcontractors.**

   1. To enter into written agreements with any agents, including subcontractors and vendors, to whom Business Associate provides PHI or PI received from or created or received by Business Associate on behalf of DHCS, that impose the same restrictions and conditions on such agents, subcontractors and vendors that apply to Business Associate with respect to such PHI and PI under this Addendum, and that comply with all applicable provisions of HIPAA, the HITECH Act the HIPAA regulations, and the Final Omnibus Rule, including the requirement that any agents, subcontractors or vendors implement reasonable and appropriate administrative, physical, and technical safeguards to protect such PHI and PI. Business associates are directly liable under the HIPAA Rules and subject to civil and, in some cases, criminal penalties for making uses and disclosures of protected health information that are not authorized by its contract or required by law. A business associate also is directly liable and subject to civil penalties for failing to safeguard electronic protected health information in accordance with the HIPAA Security Rule. A “business associate” also is a subcontractor that creates, receives, maintains, or transmits protected health information on behalf of another business associate. Business Associate shall incorporate, when applicable, the relevant provisions of this Addendum into each subcontract or subaward to such agents, subcontractors and vendors, including the requirement that any security incidents or breaches of unsecured PHI or PI be reported to Business Associate.
2. In accordance with 45 CFR section 164.504(e)(1)(ii), upon Business Associate’s knowledge of a material breach or violation by its subcontractor of the agreement between Business Associate and the subcontractor, Business Associate shall:

   a. Provide an opportunity for the subcontractor to cure the breach or end the violation and terminate the agreement if the subcontractor does not cure the breach or end the violation within the time specified by DHCS; or

   b. Immediately terminate the agreement if the subcontractor has breached a material term of the agreement and cure is not possible.

F. **Availability of Information to DHCS and Individuals.** To provide access and information:

1. To provide access as DHCS may require, and in the time and manner designated by DHCS (upon reasonable notice and during Business Associate’s normal business hours) to PHI in a Designated Record Set, to DHCS (or, as directed by DHCS), to an Individual, in accordance with 45 CFR section 164.524. Designated Record Set means the group of records maintained for DHCS that includes medical, dental and billing records about individuals; enrollment, payment, claims adjudication, and case or medical management systems maintained for DHCS health plans; or those records used to make decisions about individuals on behalf of DHCS. Business Associate shall use the forms and processes developed by DHCS for this purpose and shall respond to requests for access to records transmitted by DHCS within fifteen (15) calendar days of receipt of the request by producing the records or verifying that there are none.

2. If Business Associate maintains an Electronic Health Record with PHI, and an individual requests a copy of such information in an electronic format, Business Associate shall provide such information in an electronic format to enable DHCS to fulfill its obligations under the HITECH Act, including but not limited to, 42 U.S.C. section 17935(e).

3. If Business Associate receives data from DHCS that was provided to DHCS by the Social Security Administration, upon request by DHCS, Business Associate shall provide DHCS with a list of all employees, contractors and agents who have access to the Social Security data, including employees, contractors and agents of its subcontractors and agents.

G. **Amendment of PHI.** To make any amendment(s) to PHI that DHCS directs or agrees to pursuant to 45 CFR section 164.526, in the time and manner designated by DHCS.

H. **Internal Practices.** To make Business Associate’s internal practices, books and records relating to the use and disclosure of PHI received from DHCS, or created or received by Business Associate on behalf of DHCS, available to DHCS or to the Secretary of the U.S. Department of Health and Human Services in a time and manner designated by DHCS or by the Secretary, for purposes of determining DHCS’ compliance with the HIPAA regulations. If any information needed for this purpose is in the exclusive possession of any other entity or person and the other entity or person fails or refuses to furnish the information to Business Associate, Business Associate shall so certify to DHCS and shall set forth the efforts it made to obtain the information.
I. **Documentation of Disclosures.** To document and make available to DHCS or (at the direction of DHCS) to an Individual such disclosures of PHI, and information related to such disclosures, necessary to respond to a proper request by the subject Individual for an accounting of disclosures of PHI, in accordance with the HITECH Act and its implementing regulations, including but not limited to 45 CFR section 164.528 and 42 U.S.C. section 17935(c). If Business Associate maintains electronic health records for DHCS as of January 1, 2009, Business Associate must provide an accounting of disclosures, including those disclosures for treatment, payment or health care operations, effective with disclosures on or after January 1, 2014. If Business Associate acquires electronic health records for DHCS after January 1, 2009, Business Associate must provide an accounting of disclosures, including those disclosures for treatment, payment or health care operations, effective with disclosures on or after the date the electronic health record is acquired, or on or after January 1, 2011, whichever date is later. The electronic accounting of disclosures shall be for disclosures during the three years prior to the request for an accounting.

J. **Breaches and Security Incidents.** During the term of this Agreement, Business Associate agrees to implement reasonable systems for the discovery and prompt reporting of any breach or security incident, and to take the following steps:

1. **Notice to DHCS.** (1) To notify DHCS immediately upon the discovery of a suspected security incident that involves data provided to DHCS by the Social Security Administration. This notification will be by telephone call plus email or fax upon the discovery of the breach. (2) To notify DHCS within 24 hours by email or fax of the discovery of unsecured PHI or PI in electronic media or in any other media if the PHI or PI was, or is reasonably believed to have been, accessed or acquired by an unauthorized person, any suspected security incident, intrusion or unauthorized access, use or disclosure of PHI or PI in violation of this Agreement and this Addendum, or potential loss of confidential data affecting this Agreement. A breach shall be treated as discovered by Business Associate as of the first day on which the breach is known, or by exercising reasonable diligence would have been known, to any person (other than the person committing the breach) who is an employee, officer or other agent of Business Associate.

   Notice shall be provided to the DHCS Program Contract Manager, the DHCS Privacy Officer and the DHCS Information Security Officer. If the incident occurs after business hours or on a weekend or holiday and involves data provided to DHCS by the Social Security Administration, notice shall be provided by calling the DHCS EITS Service Desk. Notice shall be made using the “DHCS Privacy Incident Report” form, including all information known at the time. Business Associate shall use the most current version of this form, which is posted on the DHCS Privacy Office website (www.dhcs.ca.gov, then select “Privacy” in the left column and then “Business Use” near the middle of the page) or use this link: http://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/DHCSBusinessAssociatesOnly.aspx

   Upon discovery of a breach or suspected security incident, intrusion or unauthorized access, use or disclosure of PHI or PI, Business Associate shall take:

   a. Prompt corrective action to mitigate any risks or damages involved with the breach and to protect the operating environment; and

   b. Any action pertaining to such unauthorized disclosure required by applicable Federal and State laws and regulations.
2. **Investigation and Investigation Report.** To immediately investigate such security incident, breach, or unauthorized access, use or disclosure of PHI or PI. If the initial report did not include all of the requested information marked with an asterisk, then within 72 hours of the discovery, Business Associate shall submit an updated “DHCS Privacy Incident Report” containing the information marked with an asterisk and all other applicable information listed on the form, to the extent known at that time, to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer:

3. **Complete Report.** To provide a complete report of the investigation to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer within ten (10) working days of the discovery of the breach or unauthorized use or disclosure. If all of the required information was not included in either the initial report, or the Investigation Report, then a separate Complete Report must be submitted. The report shall be submitted on the “DHCS Privacy Incident Report” form and shall include an assessment of all known factors relevant to a determination of whether a breach occurred under applicable provisions of HIPAA, the HITECH Act, the HIPAA regulations and/or state law. The report shall also include a full, detailed corrective action plan, including information on measures that were taken to halt and/or contain the improper use or disclosure. If DHCS requests information in addition to that listed on the “DHCS Privacy Incident Report” form, Business Associate shall make reasonable efforts to provide DHCS with such information. If necessary, a Supplemental Report may be used to submit revised or additional information after the completed report is submitted, by submitting the revised or additional information on an updated “DHCS Privacy Incident Report” form. DHCS will review and approve or disapprove the determination of whether a breach occurred, is reportable to the appropriate entities, if individual notifications are required, and the corrective action plan.

4. **Notification of Individuals.** If the cause of a breach of PHI or PI is attributable to Business Associate or its subcontractors, agents or vendors, Business Associate shall notify individuals of the breach or unauthorized use or disclosure when notification is required under state or federal law and shall pay any costs of such notifications, as well as any costs associated with the breach. The notifications shall comply with the requirements set forth in 42 U.S.C. section 17932 and its implementing regulations, including, but not limited to, the requirement that the notifications be made without unreasonable delay and in no event later than 60 calendar days. The DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer shall approve the time, manner and content of any such notifications and their review and approval must be obtained before the notifications are made.

5. **Responsibility for Reporting of Breaches.** If the cause of a breach of PHI or PI is attributable to Business Associate or its agents, subcontractors or vendors, Business Associate is responsible for all required reporting of the breach as specified in 42 U.S.C. section 17932 and its implementing regulations, including notification to media outlets and to the Secretary. If a breach of unsecured PHI involves more than 500 residents of the State of California or its jurisdiction, Business Associate shall notify the Secretary of the breach immediately upon discovery of the breach. If Business Associate has reason to believe that duplicate reporting of the same breach or incident may occur because its subcontractors, agents or vendors may report the breach or incident to DHCS in addition to Business Associate, Business Associate shall notify DHCS, and DHCS and Business Associate may take appropriate action to prevent duplicate reporting. The breach reporting requirements of this paragraph are in addition to the reporting requirements set forth in subsection 1, above.

6. **DHCS Contact Information.** To direct communications to the above referenced DHCS staff, the Contractor shall initiate contact as indicated herein. DHCS reserves the right to make changes to the
contact information below by giving written notice to the Contractor. Said changes shall not require an amendment to this Addendum or the Agreement to which it is incorporated.

<table>
<thead>
<tr>
<th>DHCS Program Contract Manager</th>
<th>DHCS Privacy Officer</th>
<th>DHCS Information Security Officer</th>
</tr>
</thead>
</table>
| See the Scope of Work exhibit for Program Contract Manager information | Privacy Officer  
c/o: Office of HIPAA Compliance  
Department of Health Care Services  
P.O. Box 997413, MS 4722  
Sacramento, CA 95899-7413  
Email: privacyofficer@dhcs.ca.gov  
Telephone: (916) 445-4646  
Fax: (916) 440-7680 | Information Security Officer  
DHCS Information Security Office  
P.O. Box 997413, MS 6400  
Sacramento, CA 95899-7413  
Email: iso@dhcs.ca.gov  
Fax: (916) 440-5537  
Telephone: EITS Service Desk  
(916) 440-7000 or  
(800) 579-0874 |

K. **Termination of Agreement.** In accordance with Section 13404(b) of the HITECH Act and to the extent required by the HIPAA regulations, if Business Associate knows of a material breach or violation by DHCS of this Addendum, it shall take the following steps:

1. Provide an opportunity for DHCS to cure the breach or end the violation and terminate the Agreement if DHCS does not cure the breach or end the violation within the time specified by Business Associate; or
2. Immediately terminate the Agreement if DHCS has breached a material term of the Addendum and cure is not possible.

L. **Due Diligence.** Business Associate shall exercise due diligence and shall take reasonable steps to ensure that it remains in compliance with this Addendum and is in compliance with applicable provisions of HIPAA, the HITECH Act and the HIPAA regulations, and that its agents, subcontractors and vendors are in compliance with their obligations as required by this Addendum.

M. **Sanctions and/or Penalties.** Business Associate understands that a failure to comply with the provisions of HIPAA, the HITECH Act and the HIPAA regulations that are applicable to Business Associate may result in the imposition of sanctions and/or penalties on Business Associate under HIPAA, the HITECH Act and the HIPAA regulations.

IV. Obligations of DHCS

DHCS agrees to:

A. **Notice of Privacy Practices.** Provide Business Associate with the Notice of Privacy Practices that DHCS produces in accordance with 45 CFR section 164.520, as well as any changes to such notice. Visit the DHCS Privacy Office to view the most current Notice of Privacy Practices at: [http://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/default.aspx](http://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/default.aspx) or the DHCS website at [www.dhcs.ca.gov](http://www.dhcs.ca.gov) (select “Privacy in the left column and “Notice of Privacy Practices” on the right side of the page).

B. **Permission by Individuals for Use and Disclosure of PHI.** Provide the Business Associate with any changes in, or revocation of, permission by an Individual to use or disclose PHI, if such changes affect the Business Associate’s permitted or required uses and disclosures.
C. **Notification of Restrictions.** Notify the Business Associate of any restriction to the use or disclosure of PHI that DHCS has agreed to in accordance with 45 CFR section 164.522, to the extent that such restriction may affect the Business Associate’s use or disclosure of PHI.

D. **Requests Conflicting with HIPAA Rules.** Not request the Business Associate to use or disclose PHI in any manner that would not be permissible under the HIPAA regulations if done by DHCS.

V. Audits, Inspection and Enforcement

A. From time to time, DHCS may inspect the facilities, systems, books and records of Business Associate to monitor compliance with this Agreement and this Addendum. Business Associate shall promptly remedy any violation of any provision of this Addendum and shall certify the same to the DHCS Privacy Officer in writing. The fact that DHCS inspects, or fails to inspect, or has the right to inspect, Business Associate’s facilities, systems and procedures does not relieve Business Associate of its responsibility to comply with this Addendum, nor does DHCS’:

1. Failure to detect or

2. Detection, but failure to notify Business Associate or require Business Associate’s remediation of any unsatisfactory practices constitute acceptance of such practice or a waiver of DHCS’ enforcement rights under this Agreement and this Addendum.

B. If Business Associate is the subject of an audit, compliance review, or complaint investigation by the Secretary or the Office of Civil Rights, U.S. Department of Health and Human Services, that is related to the performance of its obligations pursuant to this HIPAA Business Associate Addendum, Business Associate shall notify DHCS and provide DHCS with a copy of any PHI or PI that Business Associate provides to the Secretary or the Office of Civil Rights concurrently with providing such PHI or PI to the Secretary. Business Associate is responsible for any civil penalties assessed due to an audit or investigation of Business Associate, in accordance with 42 U.S.C. section 17934(c).

VI. Termination

A. **Term.** The Term of this Addendum shall commence as of the effective date of this Addendum and shall extend beyond the termination of the contract and shall terminate when all the PHI provided by DHCS to Business Associate, or created or received by Business Associate on behalf of DHCS, is destroyed or returned to DHCS, in accordance with 45 CFR 164.504(e)(2)(ii)(I).

B. **Termination for Cause.** In accordance with 45 CFR section 164.504(e)(1)(ii), upon DHCS’ knowledge of a material breach or violation of this Addendum by Business Associate, DHCS shall:

1. Provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Agreement if Business Associate does not cure the breach or end the violation within the time specified by DHCS; or

2. Immediately terminate this Agreement if Business Associate has breached a material term of this Addendum and cure is not possible.
**C. Judicial or Administrative Proceedings.** Business Associate will notify DHCS if it is named as a defendant in a criminal proceeding for a violation of HIPAA. DHCS may terminate this Agreement if Business Associate is found guilty of a criminal violation of HIPAA. DHCS may terminate this Agreement if a finding or stipulation that the Business Associate has violated any standard or requirement of HIPAA, or other security or privacy laws is made in any administrative or civil proceeding in which the Business Associate is a party or has been joined.

**D. Effect of Termination.** Upon termination or expiration of this Agreement for any reason, Business Associate shall return or destroy all PHI received from DHCS (or created or received by Business Associate on behalf of DHCS) that Business Associate still maintains in any form, and shall retain no copies of such PHI. If return or destruction is not feasible, Business Associate shall notify DHCS of the conditions that make the return or destruction infeasible, and DHCS and Business Associate shall determine the terms and conditions under which Business Associate may retain the PHI. Business Associate shall continue to extend the protections of this Addendum to such PHI, and shall limit further use of such PHI to those purposes that make the return or destruction of such PHI infeasible. This provision shall apply to PHI that is in the possession of subcontractors or agents of Business Associate.

**VII. Miscellaneous Provisions**

**A. Disclaimer.** DHCS makes no warranty or representation that compliance by Business Associate with this Addendum, HIPAA or the HIPAA regulations will be adequate or satisfactory for Business Associate’s own purposes or that any information in Business Associate’s possession or control, or transmitted or received by Business Associate, is or will be secure from unauthorized use or disclosure. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI.

**B. Amendment.** The parties acknowledge that federal and state laws relating to electronic data security and privacy are rapidly evolving and that amendment of this Addendum may be required to provide for procedures to ensure compliance with such developments. The parties specifically agree to take such action as is necessary to implement the standards and requirements of HIPAA, the HITECH Act, the HIPAA regulations and other applicable laws relating to the security or privacy of PHI. Upon DHCS’ request, Business Associate agrees to promptly enter into negotiations with DHCS concerning an amendment to this Addendum embodying written assurances consistent with the standards and requirements of HIPAA, the HITECH Act, the HIPAA regulations or other applicable laws. DHCS may terminate this Agreement upon thirty (30) days written notice in the event:

1. Business Associate does not promptly enter into negotiations to amend this Addendum when requested by DHCS pursuant to this Section; or

2. Business Associate does not enter into an amendment providing assurances regarding the safeguarding of PHI that DHCS in its sole discretion, deems sufficient to satisfy the standards and requirements of HIPAA and the HIPAA regulations.

**C. Assistance in Litigation or Administrative Proceedings.** Business Associate shall make itself and any subcontractors, employees or agents assisting Business Associate in the performance of its obligations under this Agreement, available to DHCS at no cost to DHCS to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against DHCS, its directors, officers or employees based upon claimed violation of HIPAA, the HIPAA regulations or other laws relating to security and privacy, which involves inactions or actions by the Business Associate, except where Business Associate or its subcontractor, employee or agent is a named adverse party.
D. **No Third-Party Beneficiaries.** Nothing express or implied in the terms and conditions of this Addendum is intended to confer, nor shall anything herein confer, upon any person other than DHCS or Business Associate and their respective successors or assignees, any rights, remedies, obligations or liabilities whatsoever.

E. **Interpretation.** The terms and conditions in this Addendum shall be interpreted as broadly as necessary to implement and comply with HIPAA, the HITECH Act, the HIPAA regulations and applicable state laws. The parties agree that any ambiguity in the terms and conditions of this Addendum shall be resolved in favor of a meaning that complies and is consistent with HIPAA, the HITECH Act and the HIPAA regulations.

F. **Regulatory References.** A reference in the terms and conditions of this Addendum to a section in the HIPAA regulations means the section as in effect or as amended.

G. **Survival.** The respective rights and obligations of Business Associate under Section VI.D of this Addendum shall survive the termination or expiration of this Agreement.

H. **No Waiver of Obligations.** No change, waiver or discharge of any liability or obligation hereunder on any one or more occasions shall be deemed a waiver of performance of any continuing or other obligation, or shall prohibit enforcement of any obligation, on any other occasion.
Attachment A
Business Associate Data Security Requirements

I. Personnel Controls

A. **Employee Training.** All workforce members who assist in the performance of functions or activities on behalf of DHCS, or access or disclose DHCS PHI or PI must complete information privacy and security training, at least annually, at Business Associate’s expense. Each workforce member who receives information privacy and security training must sign a certification, indicating the member’s name and the date on which the training was completed. These certifications must be retained for a period of six (6) years following contract termination.

B. **Employee Discipline.** Appropriate sanctions must be applied against workforce members who fail to comply with privacy policies and procedures or any provisions of these requirements, including termination of employment where appropriate.

C. **Confidentiality Statement.** All persons that will be working with DHCS PHI or PI must sign a confidentiality statement that includes, at a minimum, General Use, Security and Privacy Safeguards, Unacceptable Use, and Enforcement Policies. The statement must be signed by the workforce member prior to access to DHCS PHI or PI. The statement must be renewed annually. The Contractor shall retain each person’s written confidentiality statement for DHCS inspection for a period of six (6) years following contract termination.

D. **Background Check.** Before a member of the workforce may access DHCS PHI or PI, a thorough background check of that worker must be conducted, with evaluation of the results to assure that there is no indication that the worker may present a risk to the security or integrity of confidential data or a risk for theft or misuse of confidential data. The Contractor shall retain each workforce member’s background check documentation for a period of three (3) years following contract termination.

II. Technical Security Controls

A. **Workstation/Laptop encryption.** All workstations and laptops that process and/or store DHCS PHI or PI must be encrypted using a FIPS 140-2 certified algorithm which is 128bit or higher, such as Advanced Encryption Standard (AES). The encryption solution must be full disk unless approved by the DHCS Information Security Office.

B. **Server Security.** Servers containing unencrypted DHCS PHI or PI must have sufficient administrative, physical, and technical controls in place to protect that data, based upon a risk assessment/system security review.

C. **Minimum Necessary.** Only the minimum necessary amount of DHCS PHI or PI required to perform necessary business functions may be copied, downloaded, or exported.

D. **Removable media devices.** All electronic files that contain DHCS PHI or PI data must be encrypted when stored on any removable media or portable device (i.e. USB thumb drives, floppies, CD/DVD, smartphones, backup tapes etc.). Encryption must be a FIPS 140-2 certified algorithm which is 128bit or higher, such as AES.

E. **Antivirus software.** All workstations, laptops and other systems that process and/or store DHCS PHI or PI must install and actively use comprehensive anti-virus software solution with automatic updates scheduled at least daily.
F. **Patch Management.** All workstations, laptops and other systems that process and/or store DHCS PHI or PI must have critical security patches applied, with system reboot if necessary. There must be a documented patch management process which determines installation timeframe based on risk assessment and vendor recommendations. At a maximum, all applicable patches must be installed within 30 days of vendor release.

G. **User IDs and Password Controls.** All users must be issued a unique user name for accessing DHCS PHI or PI. Username must be promptly disabled, deleted, or the password changed upon the transfer or termination of an employee with knowledge of the password, at maximum within 24 hours. Passwords are not to be shared. Passwords must be at least eight characters and must be a non-dictionary word. Passwords must not be stored in readable format on the computer. Passwords must be changed every 90 days, preferably every 60 days. Passwords must be changed if revealed or compromised. Passwords must be composed of characters from at least three of the following four groups from the standard keyboard:

- Upper case letters (A-Z)
- Lower case letters (a-z)
- Arabic numerals (0-9)
- Non-alphanumeric characters (punctuation symbols)

H. **Data Destruction.** When no longer needed, all DHCS PHI or PI must be cleared, purged, or destroyed consistent with NIST Special Publication 800-88, Guidelines for Media Sanitization such that the PHI or PI cannot be retrieved.

I. **System Timeout.** The system providing access to DHCS PHI or PI must provide an automatic timeout, requiring re-authentication of the user session after no more than 20 minutes of inactivity.

J. **Warning Banners.** All systems providing access to DHCS PHI or PI must display a warning banner stating that data is confidential, systems are logged, and system use is for business purposes only by authorized users. User must be directed to log off the system if they do not agree with these requirements.

K. **System Logging.** The system must maintain an automated audit trail which can identify the user or system process which initiates a request for DHCS PHI or PI, or which alters DHCS PHI or PI. The audit trail must be date and time stamped, must log both successful and failed accesses, must be read only, and must be restricted to authorized users. If DHCS PHI or PI is stored in a database, database logging functionality must be enabled. Audit trail data must be archived for at least 3 years after occurrence.

L. **Access Controls.** The system providing access to DHCS PHI or PI must use role based access controls for all user authentications, enforcing the principle of least privilege.
Exhibit F
HIPAA Business Associate Addendum

M. Transmission encryption. All data transmissions of DHCS PHI or PI outside the secure internal network must be encrypted using a FIPS 140-2 certified algorithm which is 128bit or higher, such as AES. Encryption can be end to end at the network level, or the data files containing PHI can be encrypted. This requirement pertains to any type of PHI or PI in motion such as website access, file transfer, and E-Mail.

N. Intrusion Detection. All systems involved in accessing, holding, transporting, and protecting DHCS PHI or PI that are accessible via the Internet must be protected by a comprehensive intrusion detection and prevention solution.

III. Audit Controls

A. System Security Review. All systems processing and/or storing DHCS PHI or PI must have at least an annual system risk assessment/security review which provides assurance that administrative, physical, and technical controls are functioning effectively and providing adequate levels of protection. Reviews should include vulnerability scanning tools.

B. Log Reviews. All systems processing and/or storing DHCS PHI or PI must have a routine procedure in place to review system logs for unauthorized access.

C. Change Control. All systems processing and/or storing DHCS PHI or PI must have a documented change control procedure that ensures separation of duties and protects the confidentiality, integrity and availability of data.

IV. Business Continuity / Disaster Recovery Controls

A. Emergency Mode Operation Plan. Contractor must establish a documented plan to enable continuation of critical business processes and protection of the security of electronic DHCS PHI or PI in the event of an emergency. Emergency means any circumstance or situation that causes normal computer operations to become unavailable for use in performing the work required under this Agreement for more than 24 hours.

B. Data Backup Plan. Contractor must have established documented procedures to backup DHCS PHI to maintain retrievable exact copies of DHCS PHI or PI. The plan must include a regular schedule for making backups, storing backups offsite, an inventory of backup media, and an estimate of the amount of time needed to restore DHCS PHI or PI should it be lost. At a minimum, the schedule must be a weekly full backup and monthly offsite storage of DHCS data.

V. Paper Document Controls

A. Supervision of Data. DHCS PHI or PI in paper form shall not be left unattended at any time, unless it is locked in a file cabinet, file room, desk or office. Unattended means that information is not being observed by an employee authorized to access the information. DHCS PHI or PI in paper form shall not be left unattended at any time in vehicles or planes and shall not be checked in baggage on commercial airplanes.

B. Escorting Visitors. Visitors to areas where DHCS PHI or PI is contained shall be escorted and DHCS PHI or PI shall be kept out of sight while visitors are in the area.

C. Confidential Destruction. DHCS PHI or PI must be disposed of through confidential means, such as cross cut shredding and pulverizing.
D. **Removal of Data.** DHCS PHI or PI must not be removed from the premises of the Contractor except with express written permission of DHCS.

E. **Faxing.** Faxes containing DHCS PHI or PI shall not be left unattended and fax machines shall be in secure areas. Faxes shall contain a confidentiality statement notifying persons receiving faxes in error to destroy them. Fax numbers shall be verified with the intended recipient before sending the fax.

F. **Mailing.** Mailings of DHCS PHI or PI shall be sealed and secured from damage or inappropriate viewing of PHI or PI to the extent possible. Mailings which include 500 or more individually identifiable records of DHCS PHI or PI in a single package shall be sent using a tracked mailing method which includes verification of delivery and receipt, unless the prior written permission of DHCS to use another method is obtained.