Exhibit A
SCOPE OF WORK

I. Service Overview

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

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

II. Service Location

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

III. Service Hours

The Services must be provided as needed on a 24-hour, seven days a week basis.

IV. Contract Representatives

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

Department of Health Care Services	**Contractor**
Managed Care Operations Division Attention: Chief, Procurement & Contract Development Branch Telephone: (916) 449-5000	Contractor**:** [Enter name] Attention: [Enter name] Telephone: (XXX) XXX-XXXX Fax: (XXX) XXX-XXXX Email: xxxxxxxx@xxxxxxxx

B. Direct all inquiries to:

Department of Health Care Services	**Contractor**
Managed Care Operations Division Attention: Contracting Officer 1501 Capitol Avenue, Suite 71.4001 P.O. Box Number 997413, Mail Stop 4408 Sacramento, CA 95899-7413 Telephone: (916) 449-5000	Attention: [Enter name] Street address & room number, if applicable P.O. Box Number, if applicable City, State, Zip Code Telephone: (XXX) XXX-XXXX Fax: (XXX) XXX-XXXX Email: xxxxxxxx@xxxxxxxx

Exhibit A
SCOPE OF WORK

C. Either party may make changes to the information in provision 4 of this Exhibit A by giving written notice to the other party. Said changes must not require an amendment to this Contract.

V. Americans with Disabilities Act

Contractor agrees to ensure that deliverables developed and produced, pursuant to this Agreement must comply with the accessibility requirements of Section 508 of the Rehabilitation Act of 1973 (29 United States Code (USC) section 794d) and the Americans with Disabilities Act of 1990 (ADA) (42 USC sections 12101, *et seq*.), as amended, and regulations implementing those statutes as set forth in 36 Code of Federal Regulations (CFR) part 1194 and 28 CFR part 36, as applicable. 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 7405 codifies section 508 of the Rehabilitation Act (29 USC section 794d) and the regulations implementing the Rehabilitation Act at 36 CFR part 1194, requiring accessibility of EIT.

The provision of the services is subject to the provisions set forth in the Exhibits and Attachments appended hereto.

Exhibit A, ATTACHMENT I

1.0 Definitions

As used in this Contract, unless otherwise expressly provided the following definitions of terms governs the construction of this Contract:

Abuse means practices that are inconsistent with sound fiscal and business practices or medical standards, and result in an unnecessary cost to the Medi-Cal program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to the Medi-Cal program.

Admission, Discharge, and Transfer (ADT) Feed means a standardized data feed, updated consistently in real-time sourced from a health facility, such as a hospital, that includes Members' demographic and healthcare Encounter Data at time of admission, discharge, and/or transfer from the facility. Demographic information within the feed must meet requirements of the most recent version of the California Data Exchange Framework's Technical Requirements for Exchange Policy and Procedure and conform to United States Core Data for Interoperability (USCDI) requirements of the California Data Exchange Framework.

Administrative Cost means only those cost that arise out of Contractor's operations as specified in 28 California Code of Regulations (CCR) section 1300.78.

Administrative Subcontractor means a Subcontractor that contractually assumes administrative obligations of Contractor under the Contract. Administrative obligations include functions such as Credentialing verification or claims processing. However, functions related to coordinating or directly delivering health care services to Members, such as Care Coordination are not administrative functions.

Adult Day Health Care (ADHC) means an organized day program of therapeutic, social and health activities, and services provided to persons 55 years or older or other adults with functional impairments, either physical or mental, for the purpose of restoring or maintaining optimal capacity for self-care as set forth in 22 CCR section 78007.

Advance Directive means a written instruction, such as a living will or durable power of attorney for health care, recognized under California law, whether statutory or as recognized by the California courts, relating to the provision of health care when a Member is incapacitated.

Adverse Benefit Determination (ABD) means any of the following actions taken by Contractor:

A. The denial or limited authorization of a requested service, including determinations based on the type or level of a Covered Service, Medical Necessity;

B. The reduction, suspension, or termination of a previously authorized Covered Service;

C. The denial, in whole or in part, of payment for a Covered Service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of Clean Claim is not an ABD;

D. The failure to provide Covered Services in a timely manner;

E. The failure to act within the required timeframes for standard resolution of Grievances and Appeals;

F. The denial of the Member's request to obtain services out-of-Network when a Member is in an area with only one Medi-Cal managed care health plan; or

G. The denial of a Member's request to dispute financial liability.

Affiliate means an entity or an individual that directly or indirectly through one or more intermediaries' controls, or is controlled by, or is under control of Contractor and that provides services to or receives services from Contractor.

All Plan Letter (APL) or **Policy Letter (PL)** means a binding document that has been dated, numbered, and issued by Department of Health Care Services (DHCS) that provides clarification of Contractor's contractual obligations, implementation instructions for Contractor's contractual obligations due to changes in State and federal law or judicial decisions, and/or guidance with regulatory force and effect when DHCS interprets, implements, or makes specific relevant State statutes under its authority.

Allied Health Personnel means specially trained, licensed, or credentialed health workers other than physicians, podiatrists and nurses.

Alternative Format Selection (AFS) means the choice a Member or a Member's Authorized Representative (AR) makes to receive information and materials in an alternate format, such as braille, large font, and electronic media, including audio or data compact discs.

American Indian means a Member who meets the criteria for an "Indian" under 42 Code of Federal Regulations (CFR) section 438.14(a).

Appeal means a review by Contractor of an Adverse Benefit Determination (ABD) which includes one of the following actions:

A. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service;

B. A reduction, suspension, or termination of a previously authorized service;

C. The denial, in whole or in part, of payment for a Covered Service, except payment denials based solely because the claim does not meet the definition of a Clean Claim;

D. Failure to provide services in a timely manner; or

E. Failure to act within the timeframes provided in 42 CFR section 438.408(b).

Application Programming Interface (API) means a way for two or more computer programs to communicate with each other. The calls that make up the API are also known as subroutines, methods, requests, or endpoints.

Asthma Preventive Services (APS) means a service that provides information about the basic facts of asthma, proper use of long-term controllers and quick relief medications, evidence-based self-management techniques and self-monitoring skills, and actions to mitigate or control environmental exposures that exacerbate asthma symptoms. Asthma Preventive Services includes evidence-based asthma self-management education and in-home environmental trigger assessments, consistent with the National Institutes of Health's Guidelines for the Diagnosis and Management of Asthma.

Authorized Representative (AR) means any individual appointed in writing by a competent Member or Potential Member, to act in place or on behalf of the Member or Potential Member for purposes of assisting or representing the Member or Potential Member with Grievances and Appeals, State Hearings, Independent Medical Reviews, and in any other capacity, as specified by the Member or Potential Member.

Auxiliary Aid means "auxiliary aids and services" as defined in 28 CFR section 36.303(b) that assist disabled Members to communicate, receive and understand information.

Basic Population Health Management (Basic PHM) means an approach to care that ensures that needed programs and services are made available to each Member, regardless of the Member's Risk Tier, at the right time and in the right setting. Basic PHM includes federal requirements for Care Coordination.

Behavioral Health means mental health conditions and Substance Use Disorders (SUD).

Behavioral Health Services means Specialty Mental Health Services (SMHS), Non-Specialty Mental Health Services (NSMHS), and Substance Use Disorders (SUD) treatment.

Behavioral Health Treatment (BHT) means services and treatment programs including applied behavioral analysis and other evidence-based intervention programs, that prevent or minimize the adverse effects of symptoms and behaviors that may interfere with learning and social interaction and promote, to the maximum extent practicable, the functioning of a Member under 21 years of age, including those diagnosed with Autism Spectrum Disorder (ASD), as determined to be medically necessary for the child by a licensed physician or psychologist.

BHT Provider means a Qualified Autism Services (QAS) Provider, QAS Professional, or QAS Paraprofessional.

Beneficiary Identification Card means a plastic card issued by DHCS to a Member confirming Medi-Cal eligibility.

Bright Futures Periodicity Schedule means the *Bright Futures/American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care* and guidelines published by the American Academy of Pediatrics and Bright Futures, in accordance with which all Members less than 21 years of age must receive well child assessments, screenings, and services.

California Advancing and Innovating Medi-Cal (**CalAIM) Terms and Conditions** means those terms and conditions issued and approved by the federal Centers for Medicare & Medicaid Services (CMS), including any attachments, appendices, or similar documents, and subsequent amendments thereto, that govern implementation of the respective components of the CalAIM initiative pursuant to Article 5.1 of Chapter 7 of Part 3 of Division 9 of Welfare and Institutions Code (W&I). CalAIM Terms and Conditions must include, at a minimum, any terms and conditions specified in the following:

A. CalAIM Demonstration, Number 11-W-00193/9, as approved by CMS pursuant to 42 United States Code (USC) section 1315, including for any applicable extension period, or for any period otherwise specified in the CalAIM Terms and Conditions.

B. Any associated Medicaid waivers as approved by CMS pursuant to 42 USC section 1396n, including but not limited to the CalAIM Section 1915(b) Waiver Control Number CA 17.R10, that are necessary to implement a CalAIM component, including for any applicable extension period, or for any period otherwise specified in the CalAIM Terms and Conditions.

California Children's Services (CCS) and Medical Therapy Program (MTP) Referral means a request for CCS/MTP enrollment for authorization of medical services for a potential eligible condition. A complete referral includes the applicant's demographic information, name of parents and/or legal guardian, and current medical reports indicating the presence of a potential CCS medically eligible condition.

California Children's Services (CCS)-Eligible Condition means a medical condition that qualifies a Child to receive medical services under the CCS Program, as specified in 22 CCR section 41515.1 *et seq*.

California Children Services (CCS) Provider means any of the following Providers when used to treat Members for a CCS-Eligible Condition:

A. A medical Provider that is paneled by the CCS Program, pursuant to Health and Safety Code (H&S), Article 5 (commencing with section 123800) of Chapter 3 of Part 2 of Division 106.

B. A licensed acute care hospital approved by the CCS Program.

C. A special care center approved by the CCS Program.

California Medicaid Section 1115 Demonstration Projects means the CalAIM and BH-CONNECT demonstration projects for which the State has obtained waivers from CMS under 42 USC section 1315.

CCS Case Management means a Member and family centered care approach to ensure needed clinical and non-clinical services for the CCS-Eligible Condition are made available to each CCS Member through comprehensive, interdisciplinary, and person-centered care management and Care Coordination to provide case finding, authorizations for services and Care Coordination to ensure that CCS children and young adults have access to CCS paneled providers, equipment, and services necessary for treatment of the CCS-Eligible Condition.

CCS Case Manager means an individual identified as a single point-of-contact responsible for the provision of case management services and facilitation of Care Coordination for a Member receiving services under the California Children's Services (CCS) Program.

CCS Liaison means primary points of contact for the coordination of services between Contractor and County CCS Program who ensure the appropriate communication and Care Coordination are ongoing between the Contractor and County CCS Program, facilitate quarterly meetings, and provide updates to the County CCS Program as appropriate.

CCS Program means a State program administered as a partnership between the county health department and DHCS to provide Medically Necessary services to treat California Children's Services (CCS)-Eligible Conditions.

Capitation Payment means a regularly scheduled payment made by DHCS to Contractor on behalf of each Member for each month the Member is enrolled with Contractor that is based on the actuarially sound capitation rate for the provision of

Covered Services and paid regardless of whether a Member receives services during the period covered by the payment.

Care Coordination means Contractor's coordination of care delivery and services for Members, either within or- across delivery systems including:

A. Services the Member receives by Contractor;

B. Services the Member receives from any other managed care health plan;

C. Services the Member receives in Fee-For-Service (FFS);

D. Services the Member receives from out-of-Network Providers;

E. Services that the Member receives through carve-out programs, such as pharmacy, Substance Use Disorder (SUD), mental health, and dental services; and

F. Services the Member receives from community and social support Providers.

Care Management Plan (CMP) means a written plan that is developed with input from the Member and/or their family member(s), parent, legal guardian, Authorized Representative (AR), caregiver, and/or other authorized support person(s) as appropriate to assess strengths, risks, needs, goals, and preferences, and make recommendations for clinical and non-clinical service needs.

Center of Excellence means a designation assigned to a transplant program by DHCS upon confirmation that the transplant program meets DHCS' criteria.

Certified Nurse Midwife (CNM) means a registered nurse who has successfully completed a program of study and clinical experience meeting the State guidelines or has been certified by an organization recognized by the State.

Child/Children and Youth, regardless of whether the term is capitalized or not, means a Member/Members less than 21 years of age unless otherwise specified.

Children and Youth with Special Health Care Needs (CYSHCN) means Children and Youth who have or are at increased risk for chronic physical, developmental, behavioral, or emotional condition and who also require health or related services of a type or amount beyond that required by Children and Youth generally. The identification, assessment, treatment, and coordination of care for CYSHCN must comply with the requirements of 42 CFR sections 438.208(b)(3), 438.208(b)(4), and 438.208(c)(2) – (4).

Clean Claim means a claim that can be processed without obtaining additional information from the Provider or from a third party, including bills, or invoices that meet DHCS established billing and invoicing requirements.

Closed-Loop Referral (CLR) means a referral initiated on behalf of a Member to a service or support that is supported, tracked and monitored and results in a Known Closure as outlined in Exhibit A, Attachment III, Subsection 4.3.8.A.12 (*Basic Population Health Management*).

Cold-Call Marketing means Contractor's or its agent's unsolicited personal contact with a Member or a Potential Member for the purpose of Marketing.

Community Based Adult Services (CBAS) means skilled nursing, social services, therapies, personal care, family/caregiver training and support, nutrition services, transportation, and other services provided in an outpatient, facility-based program, as set forth in the CalAIM Terms and Conditions, or as set forth in any subsequent demonstration amendment or renewal, or successive demonstration, waiver, or other Medicaid authority governing the provision of CBAS services.

CBAS Discharge Plan of Care means a discharge plan of care based on the Member's Community Based Adult Services (CBAS) assessment that is prepared by the CBAS Provider pursuant to 22 CCR section 78345 before the date of the Member's first reassessment and reviewed and updated at the time of each reassessment and prior to discharge.

CBAS Emergency Remote Services (ERS) means the following services, provided in alternative Service Locations such as a community setting or the Member's home, and/or as appropriate, via Telehealth or live virtual video conferencing, as clinically appropriate: professional nursing care, personal care services, social services, Behavioral Health Services, speech therapy, therapeutic activities, registered dietician-nutrition counseling, physical therapy, occupational therapy, and meals.

CBAS Individual Plan of Care (IPC) means a written plan of care developed by a Community Based Adult Services (CBAS) center's multidisciplinary team, as specified in the CalAIM Terms and Conditions, or as specified in any subsequent demonstration amendment or renewal, or successive demonstration, waiver, or other Medicaid authority governing the provision of CBAS.

CBAS Provider means an Adult Day Health Care (ADHC) center that is licensed by the California Department of Public Health (CDPH) to provide ADHC services, is enrolled as a Medi-Cal Provider, and has been certified as a Community Based Adult Services (CBAS) Provider by the California Department of Aging.

Community Health Assessment (CHA) means a systematic examination of the health status indicators for a given population that is used to identify key problems and assets in a community. Public health departments such as State, local, territorial, or Tribal develop CHAs to meet voluntary Public Health Accreditation Board (PHAB) standards and State Future of Public Health funding requirements. A variety of tools and processes may be used to conduct these population-level assessments. The essential

feature, as defined by the PHAB, is that the assessment is developed through a participatory, collaborative process with various key sectors of the community.

Community Health Improvement Plan (CHIP) means the output of the CHA when produced by public health departments (local, territorial, State, or Tribal) for Public Health Accreditation Board (PHAB) accreditation, State Local Assistance Spending Plan funding allocation, and non-profit hospitals to meet federal and State requirements.

Community Health Worker (CHW) means an individual known by a variety of job titles, such as promotores, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals, and as set forth in APL 22-016.

Community Reinvestment Plan means a document outlining the reinvestment activities in local communities.

Community Supports means services designed to help improve the health and well-being of Members, as defined in 42 CFR section 438.3(e)(2) and authorized by the California Medicaid Section 1115 Demonstration Projects. These services are optional for Contractor to offer and for Members to utilize, except for Transitional Rent, which becomes a mandatory service effective January 1, 2026.

Community Supports Provider means entities that Contractor has determined can provide the Community Supports to eligible Members in an effective manner consistent with culturally and linguistically appropriate care, as outlined in Exhibit A, Attachment III, Subsection 5.2.11 (*Cultural and Linguistic Programs and Committees*).

Complex Care Management (CCM) means an approach to care management that meets differing needs of high and rising-risk Members, including both longer-term chronic Care Coordination for chronic conditions and interventions for episodic, temporary needs. Contractors must provide CCM in accordance with all National Committee for Quality Assurance (NCQA) CCM requirements.

Complex Care Needs means the multifaceted health and social support requirements of Members who face significant barriers to achieving and maintaining health and stability. This includes individuals with multiple chronic conditions, functional impairments, behavioral health challenges, or those requiring extensive Care Coordination due to social determinants of health.

CCM Care Manager means an individual identified as a single point-of-contact responsible for the provision of Complex Care Management (CCM) services for a Member.

Confidential Information means facts, documents, or records in any form that are recognized as "confidential" by any law, regulation, or contract.

Contract means this written agreement between DHCS and Contractor.

Contract Revenues means the amount of Medi-Cal managed health care Capitation Payments, Supplemental Payments, additional payments, and other revenue paid to Contractor by DHCS under this Contract.

Contractor's Representative means an individual appointed by Contractor who is responsible for implementing this Contract, receiving notices on this Contract, and taking actions and making representations related to the compliance with this Contract.

Correctional Facility means State prisons, county jails, and youth correctional facilities.

Corrective Actions means specific identifiable activities or undertakings of Contractor which address Contract deficiencies or noncompliance.

Cost Avoid or **Cost Avoidance** means the practice of requiring Providers to bill liable third parties prior to seeking payment from the Medi-Cal program.

County CCS Program means the CCS county office that administers the CCS Program (Dependent or Independent) at the local level.

County Social Services Department means a county agency responsible for determining the initial and continued eligibility of an individual for participation in the Medi-Cal program or for providing services as specified in this Contract.

Covered Services means those health care services set forth in W&I sections 14000 *et seq.* and 14131 *et seq.,* 22 CCR section 51301 *et seq*., 17 CCR section 6800 *et seq*., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Medicaid Section 1115 Demonstration Projects, this Contract, and APLs that are made the responsibility of Contractor pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS.

Covered Services do not include:

A. Home and Community-Based Services (HCBS) program as specified in Exhibit A, Attachment III, Subsections 4.3.15 (*Services for Persons with Developmental Disabilities*), 4.3.20 (*Home and Community-Based Services Programs*) regarding waiver programs, 4.3.21 (*In-Home Supportive Services*), and Department of Developmental Services (DDS) Administered Medicaid Home and Community-Based Services Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under this Contract, as specified in Exhibit A, Attachment III, Subsection 4.3.11.F.4 (*Targeted Case Management Services*), regarding

services for Members less than 21 years of age. Contractor is financially responsible for the payment of all EPSDT services;

B. California Children's Services (CCS) as specified in Exhibit A, Attachment III, Subsection 4.3.14 (*California Children's Services*), except for Contractors providing Whole Child Model (WCM) services;

C. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (*Mental Health Services*);

D. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as specified in Exhibit A, Attachment III, Subsection 4.3.13 (*Alcohol and Substance Use Disorder Treatment Services*);

E. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (*Services for All Members*);

F. Direct Observed Therapy for Treatment of Tuberculosis as specified in Exhibit A, Attachment III, Subsection 4.3.18 (*Direct Observed Therapy for Treatment of Tuberculosis*);

G. Dental services as specified in W&I sections 14131.10, 14132(h), 14132.22, 14132.23, and 14132.88, and EPSDT dental services as described in 22 CCR section 51340.1(b). However, Contractor is responsible for all Covered Services as specified in Exhibit A, Attachment III, Subsection 4.3.17 (*Dental*) regarding dental services;

H. Prayer or spiritual healing as specified in 22 CCR section 51312;

I. Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency (LEA) and provided pursuant to a Member's Individualized Education Plan (IEP) as set forth in Education Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, Contractor is responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (*School-Based Services*);

J. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH);

K. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services;

L. State Supported Services;

M. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (*Targeted Case Management Services*). However, if Members less than 21 years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, Contractor must ensure access to comparable services under the EPSDT benefit in accordance with APL 23-005;

N. Childhood lead poisoning case management provided by county or State health departments;

O. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living;

P. End of life services as stated in Health and Safety Code (H&S) section 443 *et seq*., and APL 16-006; and

Q. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with APL 25-013.

Credentialing means the process of determining a Provider or an entity's professional or technical competence, and may include registration, certification, licensure, and professional association membership.

Deemed Exhaustion means Contractor's failure to adhere to the notice and timing requirements in responding to a Member's Appeal of an Adverse Benefit Determination (ABD), which allows a Member to immediately request a State Hearing.

Department of Health Care Services (DHCS) or **Department** means the single State department responsible for the administration of the Medi-Cal Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health-related programs, as provided by statute and/or regulation.

DHCS Comprehensive Quality Strategy means the federally required written strategy produced by the State, pursuant to 42 CFR section 438.340 that assesses and improves the quality of health care and services furnished by Medi-Cal managed care health plans.

DHCS Contract Manager or **DHCS Program Contract Manager** means the designated DHCS employee who is the primary contact within DHCS for this Contract, and responsible for receiving and sending notices and other documents from/to Contractor relating to this Contract.

DHCS Contracting Officer means the DHCS individual authorized to act on behalf of DHCS to make decisions and direct appropriate actions under this Contract.

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

Developmental Disability (DD) means, as defined by the Lanterman Developmental Disabilities Services Act (1977) at W&I section 4512(a)(1), a disability that originates before an individual attains 18 years of age, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual. This term includes intellectual disability, cerebral palsy, epilepsy, and autism. This term also includes disabling conditions found to be closely related to intellectual disability but does not include other handicapping conditions that are solely physical in nature.

Director means the Director of DHCS.

Directed Payment Initiative means a payment arrangement that directs certain expenditures made by Contractor under this Contract and that is either approved by CMS as described in 42 CFR section 438.6(c) or established pursuant to 42 CFR sections 438.6(c)(1)(iii)(A) and 438.6(c)(2)(ii) and documented in a rate certification approved by CMS.

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

Discrimination Grievance means any complaint or grievance alleging discrimination prohibited by State non-discrimination law, including, without limitation, the Unruh Civil Rights Act and GC section 11135, and federal non-discrimination law, including, without limitation, Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972; the Age Discrimination Act of 1975; Sections 504 and 508 of the Rehabilitation Act of 1973 (29 USC sections 794 and 794d), as amended; Titles II and III of the Americans with Disabilities Act of 1990, as amended; and Section 1557 of the Patient Protection and Affordable Care Act of 2010 (42 USC section 18116).

Doula means a birth worker who provides health education, advocacy, and physical, emotional, and nonmedical support for pregnant and postpartum persons before, during, and after childbirth, otherwise known as the perinatal period, for up to one year after pregnancy and provides support during miscarriage, stillbirth, and abortion (pregnancy termination) as set forth in APL 23-024.

Downstream Subcontractor means an individual or an entity that has a Downstream Subcontractor Agreement with a Subcontractor or a Downstream Subcontractor. A Network Provider is not a Downstream Subcontractor solely because it enters into a Network Provider Agreement.

Downstream Fully Delegated Subcontractor means a Downstream Subcontractor that contractually assumes all duties and obligations of Contractor under the Contract, through the Subcontractor, except for those contractual duties and obligations where delegation is legally or contractually prohibited. A managed care plan can operate as a Downstream Fully Delegated Subcontractor.

Downstream Partially Delegated Subcontractor means a Downstream Subcontractor that contractually assumes some, but not all, duties and obligations of a Subcontractor under the Contract, including, for example, obligations regarding specific Member populations or obligations regarding a specific set of services. Individual physician associations and medical groups often operate as Downstream Partially Delegated Subcontractors.

Downstream Administrative Subcontractor means a Downstream Subcontractor that contractually assumes administrative obligations of a Subcontractor under the Contract. Administrative obligations include functions such as credentialing verification or claims processing. However, functions related to coordinating or directly delivering health care services for Members, such as Utilization Management (UM) or Care Coordination, are not administrative functions.

Downstream Subcontractor Agreement means a written agreement between a Subcontractor and a Downstream Subcontractor or between any Downstream Subcontractors. The Downstream Subcontractor Agreement must include a delegation of Contractor's and Subcontractor's duties and obligations under the Contract.

Drug Medi-Cal (DMC) means the State system wherein Members receive Covered Services from DMC-certified Substance Use Disorder (SUD) treatment Providers.

Drug Medi-Cal Organized Delivery System (DMC-ODS) means a program for the organized delivery of Substance Use Disorder (SUD) services to Medi-Cal-eligible individuals with SUD residing in a county that has elected to participate in the DMC-ODS. Critical elements of DMC-ODS include providing a continuum of care modeled after the American Society of Addiction Medicine (ASAM) Criteria® for SUD treatment services, increased local control and accountability, greater administrative oversight, creation of utilization controls to improve care and efficient use of resources, evidence-based practices in substance use treatment, and increased coordination with other systems of care.

Durable Medical Equipment (DME) means Medically Necessary medical equipment as defined by 22 CCR section 51160 that a Provider prescribes for a Member that the Member uses in the home, in the community, or in a facility that is used as a home.

Dyadic Care means to serve both parent(s) or caregiver(s) and Child together as a dyad and is a form of treatment that targets family well-being as a mechanism to support healthy Child development and mental health. It is provided within pediatric Primary Care settings whenever possible and can help identify Behavioral Health interventions and other Behavioral Health issues, provide referrals to services, and help guide the parent-Child or caregiver-Child relationship. Dyadic Care fosters team-based approaches to meeting family needs, including addressing mental health and social support concerns, and it broadens and improves the delivery of pediatric Preventive Care.

Dyadic Service means a family and caregiver-focused Model of Care intended to address developmental and Behavioral Health conditions of Children as soon as they are identified. Dyadic Services include Dyadic Behavioral Health (DBH) well-Child visits, Dyadic Comprehensive Community Supports Services, Dyadic Psychoeducational Services, and Dyadic Family Training and Counseling for Child Development.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) means the provision of Medically Necessary comprehensive and preventive health care services provided to Members less than 21 years of age in accordance with requirements in 42 USC sections 1396a(a)(43) and 1396d(a)(4)(B) and (r), 42 CFR section 441.50 *et seq*., and as required by W&I sections 14059.5(b) and 14132(v). Such services may also be Medically Necessary to correct or ameliorate defects and physical or Behavioral Health conditions.

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

A. Placing the Member’s health in serious jeopardy;

B. Serious impairment to bodily functions;

C. Serious dysfunction to any bodily organ or part; or

D. Death.

Emergency Medical Transportation (EMT) means transportation services for an Emergency Medical Condition and includes emergency air transportation.

Emergency Preparedness and Response Plan means the plan identified and described in Exhibit A, Attachment III, Section 6.1 (*General Requirements*).

Emergency Services means inpatient and outpatient Covered Services that are furnished by a qualified Provider and needed to evaluate or stabilize an Emergency

Medical Condition, as defined in 42 CFR section 438.114 and H&S section 1317.1(a)(1).

Encounter means an instance of direct Provider-to-Member interaction, regardless of the setting, where the Provider is diagnosing, evaluating, or treating the Member's condition.

Encounter Data means the information that describes health care interactions between Members and Providers relating to the receipt of any item(s) or service(s) by a Member under this Contract and subject to the standards of 42 CFR sections 438.242 and 438.818.

Enhanced Care Management (ECM) means a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-cost and/or high-need Members who meet ECM Populations of Focus (POF) eligibility criteria through a systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered.

ECM Lead Care Manager means a Member's designated Enhanced Care Management (ECM) care manager who works for the ECM Provider and is responsible for coordinating all aspects of ECM and any Community Supports as a part of the Member's multi-disciplinary care team, which may include other care managers.

ECM Populations of Focus/Populations of Focus (POF) means the populations identified in Exhibit A, Attachment III, Subsection 4.4.2 (*Populations of Focus for Enhanced Care Management*).

ECM Streamlined Authorization policy means that select ECM Providers as defined in Exhibit A, Attachment III, Subsection 4.4.7 (*Authorizing Members for Enhanced Care Management*) may initiate ECM services and must be reimbursed for those services for a period of up to 30 calendar days while the ECM Provider refers the Member to the Contractor and awaits the Contractors' ECM authorization decision.

ECM Provider means community-based entities with experience and expertise providing intensive, in-person care management services to Members in one or more of the Populations of Focus (POF) for Enhanced Care Management (ECM).

Enrollment means the process by which a Potential Member becomes a Member of Contractor.

Excluded Entities or **Excluded Providers** means entities, Providers, and individuals that are excluded from participation in federally funded health care programs for a variety of reasons, including a conviction for Medicare or Medicaid Fraud.

Excluded Service means a service that is covered by the Medi-Cal program but is not a Covered Service, and is carved out of this Contract for the provision of Covered Services.

External Quality Review (EQR) means the analysis and review by the External Quality Review Organization (EQRO) of aggregated information on quality, timeliness, and access to the health care services that Contractor, its Subcontractor, its Downstream Subcontractor, or its Network Provider furnishes to Members.

External Quality Review Organization (EQRO) means an organization that meets the competence and independence requirements set forth in 42 CFR section 438.354, and performs EQR and other EQR-related activities as set forth in 42 CFR section 438.358 pursuant to its contract with DHCS.

Family Therapy means a type of psychotherapy covered under the Medi-Cal Non-Specialty Mental Health Services (NSMHS) benefit and is composed of at least two family members. Family therapy sessions address family dynamics as they relate to mental status and behavior(s) and is focused on improving relationships and behaviors in the family and between family members, such as between a Child and parent(s) or caregiver(s).

Federal Financial Participation (FFP) means federal expenditures provided to reimburse allowable State expenditures made under the approved California Medicaid State Plan, waivers, or other similar federal Medicaid authority.

Federally Qualified Health Center (FQHC) means an entity defined in 42 USC section 1396d(l)(2)(B).

Federally Qualified Health Maintenance Organization (FQHMO) means a prepaid health delivery plan that has fulfilled the requirements of the Health Maintenance Organization Act, along with its amendments and regulations, and has obtained the federal government's qualification status under 42 USC section 300e.

Fee-For-Service (FFS) means the Medi-Cal delivery system in which Providers submit claims to and receive payments from DHCS for Medi-Cal Covered Services rendered to Medi-Cal recipients.

File and Use means a submission to DHCS that does not need review and approval prior to use or implementation, but for which DHCS can require edits on or after implementation.

Financial Performance Guarantee means cash or cash equivalents which are immediately redeemable upon demand by DHCS, in an amount determined by DHCS, which must not be less than one full month’s Contract Revenues.

Financial Statements means reports prepared by Contractor to present its financial performance and position at a point in time, and include a balance sheet, income statement, statement of cash flows, statement of equity and accompanying footnotes prepared in accordance with Generally Accepted Accounting Principles (GAAP).

Fiscal Year (FY) means any 12-month period for which annual accounts are kept. The State Fiscal Year (SFY) is July 1 through June 30; the federal Fiscal Year (FY) is October 1 through September 30.

Fraud means an intentional deception or misrepresentation made by persons with the knowledge that the deception could result in some unauthorized benefit to themselves or some other person and includes any act that constitutes Fraud under applicable federal or State law, including 42 CFR section 455.2 and W&I section 14043.1(i).

Freestanding Birthing Center (FBC) means a health facility that is not a hospital, where childbirth is planned to occur away from the pregnant woman's residence, and that is licensed or otherwise approved by the State to provide prenatal labor and delivery or postpartum care and other ambulatory services that are in their scope of work as defined in 42 USC section 1396d(I)(3)(B).

Fully Delegated Subcontractor means a Subcontractor that contractually assumes all duties and obligations of Contractor under the Contract, except for those contractual duties and obligations where delegation is legally or contractually prohibited. A managed care plan can operate as a Fully Delegated Subcontractor.

Governing Board means Contractor's board of directors or a similar body, and/or its executive management, that has the authority to manage and direct Contractor's affairs and activities, including, but not limited to, approving initiatives and establishing Contractor's policies and procedures.

Grievance means any expression of dissatisfaction about any matter other than an Adverse Benefit Determination (ABD), and may include, but is not limited to: the Quality of Care or services provided, aspects of interpersonal relationships with a Provider or Contractor's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by Contractor to make an authorization decision. A complaint is the same as Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other Contractor processes. If contractor is unable to distinguish between a grievance and an inquiry, it must be considered a grievance.

Health Disparity means differences in health, including mental health, and outcomes closely linked with social, economic, and environmental disadvantage, which are often driven by the social conditions in which individuals live, learn, work, and play. Characteristics such as race, ethnicity, age, disability, sexual orientation, gender identity, socio-economic status, geographic location, and other factors historically linked

to exclusion or discrimination are known to influence the health of individuals, families, and communities.

Health Equity means the reduction or elimination of Health Disparities, Health Inequities, or other disparities in health that adversely affect vulnerable populations.

Health Inequity means a systematic difference in the health status of different population groups arising from the social conditions in which Members are born, grow, live, work, and/or age, resulting in significant social and economic costs both to individuals and societies.

Healthcare Effectiveness Data and Information Set (HEDIS®) means the set of standardized performance measures sponsored and maintained by the National Committee for Quality Assurance (NCQA).

Implementation Period means the period of time in which Contractor is undertaking any readiness requirements required by DHCS before performance of the Contract begins. The Implementation Period begins with DHCS awarding this Contract and extends to the effective date that begins the Operations Period.

Incentive Arrangement means any payment mechanism approved by Centers for Medicare & Medicaid Services (CMS) in accordance with the requirements of 42 CFR section 438.6(b) under which Contractor may receive incentive payments in addition to Capitation Payments for meeting targets specified in accordance with this Contract, including but not limited to Exhibit B, Subsection 1.1.14.D (*Special Contract Provisions Related to Payment*).

Independent Medical Review (IMR) means a review of Contractor's denial of a Member's request for health care service as not Medically Necessary, experimental, or investigational by an independent physician(s) who is contracted with DMHC. The IMR decision is binding on Contractor but not the Member who may still request a State Hearing after an IMR pursuant to H&S section 1374.30 and 28 CCR section 1300.74.30.

Indian Health Care Provider (IHCP) means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (IHCIA) at 25 USC section 1603.

Indian Health Service (IHS) means an agency within the United States Department of Health and Human Services responsible for providing federal health services to American Indians and Alaska Natives. The IHS is the principal federal health care provider and health advocate for these populations and provides them with a comprehensive Indian health care delivery system.

Indian Health Services Memorandum of Agreement Provider (IHS/MOA) means an Indian Health Service (IHS) program funded under the authority of Public Law 93-638 at 25 USC section 5301 et seq. These programs have elected to participate in Medi-Cal as IHS/MOA providers. IHS/MOAs are subject to the payment terms of APL 17-020. The list of eligible IHS/MOA providers is found in APL 17-020, Attachment #1. These providers receive a federally established All-Inclusive Rate that is updated annually by the federal Office of Management and Budgets and published in APL 17-020, Attachment #2.

In-Home Supportive Services (IHSS) means services provided to Members by a county in accordance with the requirements set forth in W&I sections 12300 *et seq.*, 14132.95, 14132.952, and 14132.956.

Initial Health Appointment (IHA), previously called Initial Health Assessment, means an assessment that must be completed within 120 days of Contractor enrollment for new Members and must include a history of the Member's physical and Behavioral Health, an identification of risks, an assessment of need for preventive screens or services and health education, and a diagnosis and plan for treatment of any diseases.

Incurred but Not Reported (IBNR) Claim Estimate means a financial accounting of all services that have been performed, but have not been invoiced or recorded, or estimates of costs for medical services provided for which a claim has not yet been filed.

Intermediate Care Facility (ICF) means a health facility that meets the standards specified in 22 CCR section 51212 and provides inpatient care to ambulatory or non-ambulatory patients who have recurring need for skilled nursing supervision and need supportive care, but who do not require availability of continuous skilled nursing care.

Intermediate Care Facility/Developmentally Disabled (ICF/DD) means a facility that provides 24-hour personal care, habilitation, developmental, and supportive health services to persons with developmental disabilities whose primary need is for developmental services and who have a recurring but intermittent need for skilled nursing services. An Intermediate Care Facility/Developmentally Disabled (ICF/DD) includes the following types:

A. ICF/DD-Habilitative as defined in Health and Safety Code (H&S) section 1250(e);

B. ICF/DD-Nursing as defined in H&S section 1250(h); and

C. ICF/DD for purposes of this contract does not include the ICF/DD-Continuous Nursing Care Program.

Joint Commission (JC) means the organization that provides health care accreditation and related services that support performance improvement in health care organization and is composed of representatives of the American Hospital Association, the American

Medical Association, the American College of Physicians, the American College of Surgeons, and the American Dental Association.

Justice Involved (JI) Individuals means individuals who are currently incarcerated, or were formerly incarcerated within the past 12 months.

Known Closure means the final result of a referral loop closure for services and supports that are subject to Closed-Loop Referral requirements, which would be a Member receiving services, a Member being unable to be reached or no longer needing services or authorization, or a Provider denying the referral.

Knox-Keene Health Care Service Plan Act of 1975 (KKA) means the law that regulates health care service plans and is administrated by DMHC, commencing with H&S section 1340 *et seq*.

Laboratory Testing Site means any laboratory and any Provider site, such as a Primary Care Provider (PCP) or Specialist office or clinic, that performs tests or examinations on human biological specimens derived from the human body.

Licensed Midwife (LM) means an individual licensed to practice midwifery and assist a woman in normal childbirth as defined in California Business and Professions Code (B&P) section 2507.

Limited English Proficiency (LEP) means an inability or a limited ability to speak, read, write, or understand the English language at a level that permits the Member to interact effectively with Providers or Contractor's employees.

Local Educational Agency (LEA) means a school district, county office of education, charter school, community college district, California State University campus or University of California campus.

Local Government Agency (LGA) means a local governmental entity including, but not limited to, a county Child welfare agency, county probation department, county Behavioral Health department, county social services department, county public health department, school district, or county office of education.

Local Health Department (LHD) means a municipal, county, or regional public health department.

Long-Term Care (LTC) means specialized rehabilitative services and care provided in a Skilled Nursing Facility (SNF), subacute facility, pediatric subacute facility, Intermediate Care Facility/Developmentally Disabled (ICF/DD), ICF/DD-Habilitative (ICF/DD-H), or ICF/DD-Nursing (ICF/DD-N) homes.

Long-Term Services & Supports (LTSS) means services and supports designed to allow a Member with functional limitations and/or chronic illnesses the ability to live or

work in the setting of the Member's choice, which may include the Member's home, a worksite, a Provider-owned or controlled residential setting, a nursing facility, or other institutional setting. LTSS includes both Long-Term Care (LTC) and Home and Community-Based Services (HCBS) programs and includes carved-in and carved-out services.

Marketing means any activity conducted by or on behalf of Contractor where information regarding the services offered by Contractor is disseminated in order to persuade or influence Potential Members to enroll. Marketing also includes any similar activity to secure the endorsement of any individual or organization on behalf of Contractor.

Marketing Materials means materials produced in any medium, by or on behalf of Contractor that can be reasonably interpreted as Marketing to Potential Members. Marketing Materials include, but are not limited to, all printed materials, illustrated materials, digital materials, videos, and media scripts.

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

Medi-Cal Eligibility Data System (MEDS) means the automated eligibility information processing system operated by DHCS which provides on-line access for Medi-Cal recipient information and update of Medi-Cal recipient eligibility data.

Medi-Cal FFS Rate means the rate that DHCS pays Providers on a per unit or per procedure billing code basis.

Medi-Cal Provider Manual means the multi-part document identifying Medi-Cal benefits and billing codes published and maintained by DHCS at https://files.medi-cal.ca.gov/pubsdoco/Manuals_menu.aspx.

Medical Home means a model of organization of Primary Care that delivers the core functions of primary health care, which is comprised of comprehensive care, patient-centered, coordinated care, accessible services, and quality and safety.

Medical Records means the record of a Member's medical information, including but not limited to medical history, care or treatments received, test results, diagnoses, and prescribed medications.

Medical Therapy Program (MTP) means a special program that provides physical therapy (PT), occupational therapy (OT), and Medical Therapy Conference (MTC) services for children who have disabling conditions, generally due to neurological or musculoskeletal disorders.

Medically Necessary or **Medical Necessity** means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or alleviate

severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I section 14059.5(a) and 22 CCR section 51303(a). Medically Necessary services must include services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.

For Members less than 21 years of age, a service is Medically Necessary if it meets the EPSDT standard of Medical Necessity set forth in 42 USC section 1396d(r)(5), as required by W&I sections 14059.5(b) and 14132(v). Without limitation, Medically Necessary services for Members less than 21 years of age include all services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support, or maintain the Member's current health condition. Contractor must determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the Child.

Member or **Enrollee** means a Potential Member who has enrolled with Contractor.

Member Assignment means the written notification and assignment of a Potential Member to the Medi-Cal managed care health plan of the Member’s choice, or if as designated by DHCS when the Potential Member fails to make a timely choice.

Member Handbook or **Evidence of Coverage (EOC)** means the document that describes the health care benefits and Covered Services that are available to a Member.

Member Information means documents that are vital, or critical to obtaining benefits or services, and includes, but is not limited to: the Member Handbook, Provider Directory, welcome packets, Marketing information, form letters including Notice of Actions (NOA), notices related to Grievances or Appeals, including Grievance and Appeal acknowledgement and resolution letters, Contractor’s preventive health reminders, Member surveys, notices advising of the availability of free language assistance, and newsletters.

Memorandum of Understanding (MOU) means a formal written agreement between Contractor and Local Government Agencies, county programs, and third-party entities.

Minimum Performance Level (MPL) means a Contractor’s minimum performance requirements for select Quality Performance Measures.

Minor Consent Services means those Covered Services of a sensitive nature which minor Members under 18 years of age may, without parental or guardian consent, receive, if the minor, in the opinion of the attending professional person, is mature enough to participate intelligently in the outpatient services. Minor Consent Services include, but are not limited to the following situations:

Under Age 12

A. Pregnancy and pregnancy related services

B. Family planning services

C. Sexual assault services

Age 12 and Older

D. Pregnancy and pregnancy related services

E. Family planning services

F. Sexual assault services

G. Infectious, contagious, or communicable disease diagnosis and treatment

H. Sexually transmitted diseases (or infections) prevention, diagnosis, and treatment

I. Drug and alcohol abuse treatment and counseling

J. Outpatient mental health treatment and counseling if in the opinion of the attending professional person determines that the minor is mature enough to participate intelligently in their health care pursuant to Family Code section 6924.

K. Intimate partner violence services

Model of Care (MOC) means Contractor's approach for providing Enhanced Care Management (ECM) and Community Supports, including its Policies and Procedures for partnering with ECM and Community Supports Providers.

National Committee for Quality Assurance (NCQA) is an organization responsible for the accreditation of managed care plans and other health care entities and for developing and managing health care measures that assess the Quality of Care and services that Members receive.

National Provider Identifier (NPI) means a unique identification number for Providers. Contractor must use the NPIs in the administrative and financial transactions adopted under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Network means Primary Care Providers (PCPs), Specialists, hospitals, ancillary Providers, facilities, and other Providers with whom Contractor enters into a Network Provider Agreement.

Network Provider means any Provider or entity that has a Network Provider Agreement with Contractor, Contractor's Subcontractor, or Contractor's Downstream

Subcontractor, and receives Medi-Cal funding directly or indirectly to order, refer, or render Covered Services under this Contract. A Network Provider is not a Subcontractor or Downstream Subcontractor by virtue of the Network Provider Agreement.

Network Provider Agreement means a written agreement between a Network Provider and Contractor, Subcontractor, or Downstream Subcontractor.

Network Provider Data means information concerning all Network Providers in a Network, regardless of location, which render Covered Services to Members in a Contractor's Service Area and the provider groups, Subcontractors, and/or Downstream Subcontractors, if any, under which a Network Provider renders those services. This includes, but is not limited to, information about the contractual relationship between Network Providers, provider groups, Subcontractors, and Downstream Subcontractors within the Network, information regarding the facilities where services are rendered, and information about a Network Provider's area(s) of specialization.

No Wrong Door means Members receive timely Behavioral Health Services without delay, regardless of delivery system where they seek care and are able to maintain treatment relationships with trusted Providers without interruption. This includes concurrent service provision, whereby Contractor must cover Medically Necessary Non-Specialty Mental Health Services (NSMHS) for a Member concurrently receiving Specialty Mental Health Services (SMHS) covered by the county Mental Health Plan (MHP), and ensure those services are coordinated and not duplicative. Contractor must ensure compliance with No Wrong Door pursuant to W&I section 14184.402.

Non-Emergency Medical Transportation (NEMT) means ambulance, litter van, wheelchair van, and air medical transportation services. NEMT is used when the Member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for the purpose of obtaining needed medical care, and pursuant to 22 CCR sections 51323, 51231.1, and 51231.2, is rendered by licensed Providers.

Non-Medical Transportation (NMT) means transportation of Members to obtain Covered Services or Excluded Services by passenger car, taxicabs, or other forms of public or private conveyances, and mileage reimbursement when conveyance is in a private vehicle arranged by the Member and not through a transportation broker, bus passes, taxi vouchers, or train tickets. NMT does not include the transportation of sick, injured, invalid, convalescent, infirm, or otherwise incapacitated Members by ambulances, litter vans, or wheelchair vans licensed, operated, and equipped in accordance with State and local statutes, ordinances, or regulations.

Non-Specialty Mental Health Services (NSMHS) means all of the following services that Contractor must provide when they are Medically Necessary, and is provided by PCPs or by licensed mental health Network Providers within their scope of practice:

A. Mental health evaluation and treatment, including individual, group and family psychotherapy;

B. Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition;

C. Outpatient services for the purposes of monitoring drug therapy;

D. Psychiatric consultation; and

E. Outpatient laboratory, drugs, supplies, and supplements, excluding separately billable psychiatric drugs claimed by outpatient pharmacy providers via Medi-Cal Rx.

Operations Period means the period of time between the effective date of the first month of operations and continues on through the last month of Contractor's capitation and provision of services to Members. The Operations Period commences at the conclusion of the Implementation Period upon DHCS' acceptance of Contractor's completion of any readiness requirements required by DHCS.

Other Health Coverage (OHC) means health coverage from another entity that is responsible for payment of the reasonable value of all or part of the health care services provided to a Member. OHC may result from a health insurance policy or other contractual agreement or legal obligation to pay for health care services provided to a Member, excluding tort liability. OHC may originate under State (other than the Medi-Cal program), federal, or local medical care program, or under other contractual or legal entitlements.

Partially Delegated Subcontractor means a Subcontractor that contractually assumes some, but not all, duties and obligations of Contractor under the Contract, including, for example, obligations regarding specific Member populations or obligations regarding a specific set of services. Individual physician associations and medical groups often operate as Partially Delegated Subcontractors.

Pass-Through Payment means the "Pass-through payment," as defined in 42 CFR section 438.6(a), that has been documented in a rate certification approved by the federal Centers for Medicare & Medicaid Services (CMS).

Phaseout Period means the period of time after the date the Operations Period or Contract extension ends. The Phaseout Period extends until all activities required during the Phaseout Period for each Service Area are fully completed.

Population Health Management (PHM) means a whole-system, person-centered, population-health approach to ensuring equitable access to health care and social care that addresses Member needs. It is based on data-driven risk stratification, analytics,

identifying gaps in care, standardized screening, assessment processes, and holistic care/case management interventions.

Population Health Management (PHM) Service (also known as Medi-Cal Connect) means a data backed platform that collects and links Medi-Cal beneficiary information from disparate sources and performs Risk Stratification and Segmentation (RSS) and Risk Tiering functions, conducts analytics and reporting, identifies gaps in care, performs other population health functions, and allows for multi-party data access and use in accordance with State and federal laws, regulations, and policies.

Population Health Management Strategy (PHMS) means an annual deliverable that Contractor must submit to DHCS requiring Contractor to demonstrate that it is responding to identified community needs, to provide other updates on its PHM program as requested by DHCS, and to inform the DHCS quality assurance and Population Health Management program compliance and impact monitoring efforts.

Population Needs Assessment (PNA) means a multi-year process during which Contractor will identify and respond to the needs of its Members and the communities it serves by participating in the Community Health Assessment (CHA) of Local Health Departments (LHDs) in its Service Area. The findings of the PNA/CHA collaboration will inform Contractor's annual PHM Strategy.

Post-Payment Recovery (PPR) means Contractor's efforts to recover the cost of the services from other third-party payors responsible for the payment of a Member's health care services.

Post-Stabilization Care Services means Covered Services related to an Emergency Medical Condition that are provided after a Member's condition is stabilized, in accordance with 42 CFR section 438.114 and 28 CCR section 1300.71.4, to improve or resolve the Member's condition.

Potential Member or **Potential Enrollee** means a Medi-Cal beneficiary who resides in Contractor's Service Area and is subject to mandatory Enrollment, or who may voluntarily elect to enroll, but is not yet enrolled, in a Medi-Cal managed care health plan, and is in one of the aid codes found within Exhibit L, Article 1.0 (*Definitions*).

Prescription Drug means a drug or medication that can only be accessed through a Provider's prescription.

Preventive Care means health care designed to prevent disease, illness, injury, and/or its consequences.

Primary Care means health care usually rendered in ambulatory settings by Primary Care Providers (PCP) and mid-level practitioners that emphasizes the Member's general health needs as opposed to Specialists focusing on specific needs.

Primary Care Provider (PCP) means a Provider responsible for supervising, coordinating, and providing initial and Primary Care to Members, for initiating referrals, for maintaining the continuity of Member care, and for serving as the Medical Home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, non-physician medical practitioner, or obstetrician-gynecologist (OB-GYN). For Senior and Person with Disability (SPD) Members, a PCP may also be a Specialist or clinic.

Prior Authorization means a formal process requiring a Provider to obtain advance approval for the amount, duration, and scope of non-emergent Covered Services.

Program Data means data that includes but is not limited to: Grievance data, Appeals data, medical exemption request denial reports and other continuity of care data, out-of-Network request data, and Primary Care Provider (PCP) assignment data as of the last calendar day of the reporting month.

Provider means any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.

Provider Directory means Contractor's listing of all Network Providers and that includes the Providers' contact information, whether the Provider is accepting new Members, the hours of operation, what languages are available in the Provider's office and whether the Provider's office has accommodations, including offices, exam rooms and equipment, for people with physical disabilities.

Provider Dispute Resolution Mechanism means Contractor's obligation to include a timely, fair, and cost-effective dispute resolution process where Network Providers and out-of-Network Providers can submit disputes**.**

Provider-Preventable Condition (PPC) means a condition occurring in an inpatient hospital setting, or a condition occurring in any health care setting, that meets the criteria as stated in 42 CFR section 447.26(b).

Qualified Autism Services (QAS) Paraprofessional means an individual who is employed and supervised by a QAS Provider to provide Medically Necessary Behavioral Health Treatment (BHT) services to Members.

QAS Professional means an Associate Behavioral Analyst, Behavior Analyst, Behavior Management Assistant, or Behavior Management Consultant, as defined in the California Medicaid State Plan, who provides Medically Necessary Behavioral Health Treatment (BHT) services to Members.

QAS Provider means a licensed practitioner or Board-Certified Behavior Analyst (BCBA) who designs, supervises, or provides Medically Necessary Behavioral Health Treatment (BHT) services to Members.

Quality Improvement (QI) means systematic and continuous actions that lead to measurable improvements in the way health care is delivered and outcomes for Members.

Quality Improvement and Health Equity Committee (QIHEC) means a committee facilitated by Contractor's medical director, or the medical director's designee, in collaboration with the Health Equity officer that meets at least quarterly to direct all Quality Improvement and Health Equity Transformation Program (QIHETP) findings and required actions.

Quality Improvement and Health Equity Transformation Program (QIHETP) means the systematic and continuous activities to monitor, evaluate, and improve upon the Health Equity and health care delivered to Members in accordance with the standards set forth in applicable laws, regulations, and this Contract.

Quality Measure Compliance Audit means a thorough assessment of Contractor's information system capabilities and compliance with each Healthcare Effectiveness Data and Information Set (HEDIS®) specification to ensure accurate, reliable, and publicly reportable data.

Quality of Care means the degree to which health services for Members increase the likelihood of desired health outcomes and are consistent with current professional standards of care and knowledge.

Quality Performance Measures means tools that help measure healthcare processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality health care and/or that relate to one or more quality goals for health care.

Quantitative Treatment Limitation (QTL) means a limit on the scope or duration of a Covered Service that is expressed numerically.

Rating Period means a period selected by DHCS for which actuarially sound capitation rates are developed and documented in the rate certification submitted to CMS as required by 42 CFR section 438.7(a).

Regional Center (RC) means a non-profit, community-based entity that is contracted by Department of Developmental Services (DDS) and develops, purchases, and manages services for Members with Developmental Disabilities and their families.

Restricted Provider Database (RPD) means the database maintained by DHCS that lists Providers who are placed under a Medi-Cal payment suspension while under investigation based upon a credible allegation of Fraud, or Providers who are placed on a temporary or indefinite Medi-Cal suspension while under investigation for Fraud or Abuse, or Enrollment violations.

Retrospective Review means the process of determining Medical Necessity after treatment has been given.

Risk Sharing Mechanism means any payment arrangement, such as reinsurance, risk corridors, or stop-loss limits, documented in the CMS-approved rate certification documents for the applicable Rating Period prior to the start of the Rating Period, that is developed in accordance with 42 CFR section 438.4, the rate development standards in 42 CFR section 438.5, and generally accepted actuarial principles and practices.

Risk Stratification and Segmentation (RSS) means the process of separating Member populations into different risk groups and/or meaningful subsets, using information collected through population assessments and other data sources. RSS results in the categorization of Members with care needs at all levels and intensities.

Risk Tiering means the assigning of Members to standard Risk Tiers (low, medium-rising, or high), with the goal of determining appropriate care management programs or specific services.

Rural Health Clinic (RHC) means an entity defined in 42 USC section 1395x(aa)(2) to provide Primary Care and ambulatory services.

Safety-Net Provider means any Provider of comprehensive Primary Care or acute hospital inpatient services that provides services to a significant number of Medi-Cal recipients, patients who receives charity, and/or patients who are medically underinsured, in relation to the total number of patients served by the Provider.

School Site means a facility or location used for public kindergarten, elementary, secondary, or postsecondary purposes. “School Site” also includes a location not owned or operated by a public school, or public school district, if the school or school district provides or arranges for the provision of Medically Necessary treatment of a mental health or Substance Use Disorder to its students at that location, including off-campus clinics, mobile counseling services, and similar locations.

Screening, Assessment, Brief Intervention, and Referral to Treatment (SABIRT) Services means comprehensive, integrated delivery of early intervention and treatment services for Members with Substance Use Disorders (SUD), as well as those who are at risk of developing SUDs.

Senior and Person with Disability (SPD) means a Member who falls under a specific SPD aid code as defined by DHCS.

Service Area means the county or counties that Contractor is approved to operate in under the terms of this Contract. A Service Area may be limited to designated zip codes (under the U.S. Postal Service) within a county.

Service Location means the location where a Member obtains Covered Services under the terms of this Contract.

Significant Change means changes in Covered Services, benefits, geographic Service Area, composition of payments to its Network, or Enrollment of a new population.

Site Review means surveys and reviews conducted by DHCS or Contractor to ensure that Network Provider, Subcontractor, and Downstream Subcontractor sites have sufficient capacity to provide appropriate health care services, carry out processes that support continuity and coordination of care, maintain Member safety standards and practices, and operate in compliance with all applicable federal, State, and local laws and regulations.

Skilled Nursing Care means Covered Services provided by nurses, technicians, and/or therapists during a stay in a Skilled Nursing Facility or in a Member's home.

Skilled Nursing Facility (SNF) means any facility, place, building, agency, skilled nursing home, convalescent hospital, nursing home, or nursing facility as defined in 22 CCR section 51121, which is licensed as a SNF by California Department of Public Health (CDPH) or is a distinct part or unit of a hospital, meets the standard specified in 22 CCR section 51215 of these regulations, except that the distinct part of a hospital does not need to be licensed as a SNF, and has been certified and enrolled for participation as a SNF in the Medi-Cal program.

Social Drivers of Health (SDOH) means the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health functioning, and quality-of-life outcomes and risk. Also known as Health Related Social Needs.

Special Care Center means a center that provides comprehensive, coordinated health care to California Children's Services (CCS) and Genetically Handicapped Persons Program (GHPP) clients with specific medical conditions.

Specialist means a Provider who has completed advanced education and clinical training in a specific area of medicine or surgery. Specialists include, but are not limited to, those Specialists listed in W&I section 14197.

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

Specialty Mental Health Service (SMHS) means a Medi-Cal covered mental health service provided or arranged by county mental health plans for Members in their counties that need Medically Necessary Specialty Mental Health Services.

Standing Referral means a referral by a Primary Care Provider (PCP) to a Specialist for more than one visit to the Specialist, as indicated in the treatment plan, if any, without the Primary Care Provider having to provide a specific referral for each visit.

State means the State of California.

State Hearing means a hearing with a State Administrative Law Judge to resolve a Member's dispute about an action taken by Contractor, its Network Providers, Subcontractors, or Downstream Subcontractors.

State Supported Services means Medi-Cal services that are funded entirely by the State, and for which the State does not receive matching federal funds. These services are covered by Contractor through their Secondary Contract with DHCS for State Supported Services.

Street Medicine means a set of health and social services developed specifically to address the unique needs and circumstances of individuals experiencing unsheltered homelessness, delivered directly to them in their own environment that Contractor may offer to their Members. The fundamental approach of Street Medicine is to engage people experiencing unsheltered homelessness exactly where they are and on their own terms to maximally reduce or eliminate barriers to care access and follow-through. Street Medicine utilizes a whole person, patient-centered approach to provide Medically Necessary health care services, as well as address Social Drivers of Health that impede health care access.

Street Medicine Provider means a licensed medical Provider that renders Street Medicine services outside of the four walls of health facilities, clinics, or other health care locations, as offered by Contractor to their Members. Street Medicine Providers may provide services in various roles, such as the Member's assigned Primary Care Provider (PCP), through a direct contract with the Contractor, as an Enhanced Care Managed (ECM) Provider, as a Community Supports Provider, or as a referring or treating contracted Provider as set forth in APL 24-001.

Subacute Care means a level of care needed by a patient who does not require hospital acute care but who requires more intensive licensed Skilled Nursing Care than is provided to the majority of Members in a Skilled Nursing Facility (SNF), as defined in 22 CCR section 51124.5.

Subcontractor means an individual or entity that has a Subcontractor Agreement with Contractor that relates directly or indirectly to the performance of Contractor's obligations under this Contract. A Network Provider is not a Subcontractor solely because it enters into a Network Provider Agreement.

Subcontractor Agreement means a written agreement between Contractor and a Subcontractor. The Subcontractor Agreement must include a delegation of Contractor's duties and obligations under the Contract.

Subcontractor Network means a Network of a Subcontractor or Downstream Subcontractor, wherein the Subcontractor or Downstream Subcontractor is delegated

risk and is responsible for arranging for the provision of and paying for Covered Services as stated in their Subcontractor or Downstream Subcontractor Agreement.

Substance Use Disorder (SUD) means those set forth in the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition, published by the American Psychiatric Association.

Supplemental Payment means a payment, in addition to the Capitation Payment, made by DHCS to Contractor in accordance with Exhibit B, Section 1.7 (*Supplemental Payments*) of this Contract.

Suspended and Ineligible Provider List means the list containing the names of former Medi-Cal Providers suspended from or ineligible for participation in the Medi-Cal program. The Suspended and Ineligible Provider List is available online at https://files.medi-cal.ca.gov/pubsdoco/SandILanding.aspx.

Targeted Case Management (TCM) means services which assist Members within specified target groups to gain access to needed medical, social, educational, and other services, as set forth in 42 USC section 1396n(g). In prescribed circumstances, TCM is available as a Medi-Cal benefit and a discrete service through State or local government entities and their contractors.

Telehealth means a method of delivering health care services by using information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a Member's health care while the Member is at a separate location from the Provider.

Template Data means data reports submitted to DHCS by Contractors, which includes, but is not limited to, data of Member populations, health care benefit categories, or program initiatives.

Third Party Tort Liability (TPTL) means the contractual responsibility or tort liability of an individual or entity other than Contractor or the Member for the payment of claims for injuries, or trauma sustained by a Member.

Threshold Languages/Threshold or Concentration Standard Languages means the non-English threshold and concentration standard languages in which Contractor is required to provide written translations of Member Information, as determined by DHCS.

Transitional Care Service means a service provided to all Members transferring from one institutional care setting, or level of care, to another institution or lower level of care, including home settings.

Transitional Rent means a Community Supports service that provides up to six months of rental assistance to Members who are experiencing or at risk of homelessness, have certain clinical risk factors, and have either recently undergone a critical life transition

(such as exiting an institutional or carceral setting or foster care), or who meet other specified eligibility criteria.

Treatment Authorization Request (TAR) means certain Fee-For-Service (FFS) procedures and services that are subject to authorization by Medi-Cal field offices before reimbursement can be approved.

Tribal Federally Qualified Health Center (Tribal FQHC) means a Tribal Health Program funded under the authority of Public Law 93-638 at 25 USC sections 5301 et seq. These Health Programs have elected to participate in Medi-Cal Tribal FQHCs and are subject to the payment terms of APL 21-008. Reimbursement of Tribal FQHCs is through an Alternative Payment Methodology (APM), which is set at the federal Indian Health Service All-Inclusive Rate. The APM rate is updated annually and published in APL 21-008, Attachment #1. A list of Tribal FQHCs is published in APL 21-008, Attachment #2.

Tribal Health Program means an American Indian tribe or tribal organization that operates any health program, service, function, activity, or facility funded, in whole or part, by the Indian Health Service through, or provided for in, a contract or compact with the Indian Health Service under the Indian Health Service under the Indian Self-Determination and Education Assistance Act and is defined in 25 USC section 1603(25).

United States Department of Health and Human Services (U.S. DHHS) means the federal agency that oversees Centers for Medicare & Medicaid Services (CMS) that works in partnership with state governments to administer the Medicaid program, the Children's Health Insurance Program (CHIP), and health insurance portability standards.

Urban Indian Organization means a nonprofit corporate body situated in an urban center, governed by an urban American Indian controlled board of directors, as defined in 25 USC section 1603(29). Urban Indian Organizations participate in Medi-Cal as Tribal Federally Qualified Health Centers (Tribal FQHCs) or community clinics and are reimbursed via the Prospective Payment System or at Fee-For-Service rates.

Urgent Care means services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury.

Utilization Management (UM) or **Utilization Review** means the evaluation of the Medical Necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities.

Vaccines for Children (VFC) Program means the federally funded program that provides free vaccines for eligible Children age 18 or younger (including all Medi-Cal eligible Children age 18 or younger) and distributes immunization updates and related information to participating Providers.

Waste means the overutilization or inappropriate utilization of services and misuse of resources.

Withhold Arrangement means any payment mechanism approved by the Centers for Medicare & Medicaid Services (CMS) in accordance with the requirements of 42 CFR section 438.6(b) under which a portion of a capitation rate is withheld from Contractor, with a portion or all of the withheld amount to be paid to Contractor for meeting targets specified in this Contract, including but not limited to Exhibit B, Subsection 1.1.14.E (*Special Contract Provisions Related to Payment*).

Working Capital Ratio means a liquidity ratio, calculated as current assets divided by current liabilities, that measures Contractor's ability to pay its current liabilities with current assets. Working Capital Ratio is computed in accordance with Generally Accepted Accounting Principles (GAAP).

Working Day(s) means Monday through Friday, except for State holidays as identified at the California Department of Human Resources State Holidays page.

"Your Rights" Attachment means Contractor's written notice sent to the Member that explains the Member's rights to challenge, free of charge, Contractor's action, and the Member's right to file an Appeal with Contractor, a Deemed Exhaustion, and the right to request a State Hearing or an Independent Medical Review (IMR).

2.0 Acronyms

Medi-Cal Managed Care Contract Acronyms List

As used in this Contract, unless otherwise expressly provided or the context otherwise requires, the following acronyms are abbreviations for the corresponding terms. This Acronyms List is provided for the convenience of the parties and must not be deemed as an exhaustive or exclusive list of all acronyms in this Contract. In the event that the acronyms contained in this list are inconsistent with the provisions in the Contract, the Contract provisions will prevail.

Acronyms	Corresponding Terms
AAP	American Academy of Pediatrics
ABD	Adverse Benefit Determination
ACE	Adverse Childhood Experience
ACIP	Advisory Committee on Immunization Practices
ACOG	American College of Obstetrician and Gynecologists
ADA	Americans with Disabilities Act of 1990
ADHC	Adult Day Health Care
ADL	Activity of Daily Living
ADO	Alternate Dispute Officer
ADT	Admission, Discharge, and Transfer
AFS	Alternative Format Selection
AIDS	Acquired Immune Deficiency Syndrome
APL	All Plan Letter
API	Application Programming Interface
APS	Asthma Preventive Services
AR	Authorized Representative
ASAM	American Society of Addiction Medicine
ASD	Autism Spectrum Disorder
Basic PHM	Basic Population Health Management
BH-CONNECT	Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment
BHT	Behavioral Health Treatment
C&L	Cultural & Linguistic
CalAIM	California Advancing and Innovating Medi-Cal
CBAS	Community Based Adult Services
CB-CME	Community-Based Care Management Entities
CCM	Complex Care Management
CCR	California Code of Regulations
CCS	California Children’s Services
CDPH	California Department of Public Health
CFR	Code of Federal Regulations

Acronyms	Corresponding Terms
CHA	Community Health Assessment
CHIP	Community Health Implementation Plan
CHSP	Children's Hospital Supplemental Payment
CHW	Community Health Worker
CLIA	Clinical Laboratory Improvement Act
CLPPB	Childhood Lead Poisoning Prevention Branch
CLR	Closed-Loop Referral
CMP	Care Management Plan
CMS	The Centers for Medicare & Medicaid Services
CNM	Certified Nurse Midwife
COBA	Coordination of Benefits Agreement
COHS	County Organized Health Systems
CPSP	Comprehensive Perinatal Services Program
CPT	Current Procedural Terminology
CQI	Continuous Quality Improvement
CYSHCN	Children and Youth with Special Health Care Needs
DDS	Department of Developmental Services
DF	Disclosure Form
DHCS	Department of Health Care Services
DMC	Drug Medi-Cal
DMC-ODS	Drug Medi-Cal Organized Delivery System
DME	Durable Medical Equipment
DMFEA	Office of the Attorney General, Division of Medi-Cal Fraud and Elder Abuse
DMHC	Department of Managed Health Care
DOT	Direct Observed Therapy
D-SNP	Dual-Eligible Special Needs Plan
DUR	Drug Use Review
DVBE	Disabled Veteran Business Enterprises
ECM	Enhanced Care Management
EMT	Emergency Medical Transportation
EPSDT	Early and Periodic Screening, Diagnostic and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
ERS	CBAS Emergency Remote Services
FBC	Freestanding Birthing Centers
FDA	United States Food and Drug Administration
FFP	Federal Financial Participation
FFS	Fee-For-Service
FSP	Full Service Partnership
FQHC	Federally Qualified Health Center

Acronyms	Corresponding Terms
FSR	Facility Site Review
GAAP	Generally Accepted Accounting Principles
GC	California Government Code
H&S	Health and Safety Code
HCBS	Home and Community-Based Services
HCO	Health Care Options
HCPCS	Healthcare Common Procedure Coding System
HEDIS®	Healthcare Effectiveness Data and Information Set
HIE	Health Information Exchange
HIPAA	The Health Insurance Portability and Accountability Act of 1996
HIV	Human Immunodeficiency Virus
HMO	Health Maintenance Organization
HPA	Health Plan Accreditation
HUD	The United States Department of Housing and Urban Development
IADL	Instrumental Activity of Daily Living
ICD-10	International Classification of Diseases, Tenth Revision
ICF	Intermediate Care Facility
ICF/DD	Intermediate Care Facility Developmentally Disabled
ICF/DD-H	Intermediate Care Facility/Developmentally Disabled Habilitative
ICF/DD-N	Intermediate Care Facility/Developmentally Disabled Nursing
IEP	Individualized Education Plan
IFSP	Individualized Family Service Plan
IHA	Initial Health Appointment
IHCP	Indian Health Care Provider
IHS	Indian Health Service
IHSP	Individualized Health and Support Plan
IHSS	In-Home Supportive Services
IMD	Institution for Mental Diseases
IMR	Independent Medical Review
IPA	Independent Physician/Provider Associations
IPC	Individual Plan of Care
IT	Information Technology
JC	Joint Commission
JI	Justice Involved
KKA	Knox-Keene Health Care Service Plan Act of 1975
LEA	Local Education Agency
LEP	Limited English Proficiency
LGA	Local Government Agency
LHD	Local Health Department
LM	Licensed Midwife

Acronyms	Corresponding Terms
LTC	Long-Term Care
LTSS	Long-Term Services and Support
MAT	Medications for Addiction Treatment (or Medication-Assisted Treatment)
MCH	Maternal and Child Health
MEDS	Medi-Cal Eligibility Data System
MFTP	Money Follows the Person
MHP	County Mental Health Plan
MIS	Management and Information System
MLR	Medical Loss Ratio
MOC	Model of Care
MOU	Memorandum of Understanding
MPL	Minimum Performance Level
MSSP	Multipurpose Senior Service Program
MTP	Medical Therapy Program
NABD	Notice of Adverse Benefit Determination
NAR	Notice of Appeal Resolution
NCQA	National Committee for Quality Assurance
NDC	National Drug Code
NEMT	Non-Emergency Medical Transportation
NISTSP	National Institute of Standards and Technology Special Publication
NMT	Non-Medical Transportation
NOA	Notice of Action
NP	Nurse Practitioner
NPI	National Provider Identifier
NQTL	Non-Quantitative Treatment Limitation
NSMHS	Non-Specialty Mental Health Service
OHC	Other Health Coverage
PACE	Program for All-Inclusive Care for the Elderly
PCC	California Public Contract Code
PCP	Primary Care Provider
PCHS	Personal Care and Homemaker Services
PHI	Protected Health Information
PHM	Population Health Management
PHMS	Population Health Management Strategy
PI	Personal Information
PIA	Prison Industry Authority
PIP	Performance Improvement Project
PIR	Privacy Incident Reporting
PIU	Program Integrity Unit

Acronyms	Corresponding Terms
PL	Policy Letter
PMPM	Per Member Per Month
PNA	Population Needs Assessment
POF	Populations of Focus
PPC	Provider-Preventable Condition
PPR	Post-Payment Recovery
PSCI	Personal, Sensitive, and/or Confidential Information
QAS	Qualified Autism Services
QI	Quality Improvement
QIHEC	Quality Improvement and Health Equity Committee
QIHETP	Quality Improvement and Health Equity Transformation Program
QSO	Qualified Service Organization
QTL	Quantitative Treatment Limitation
RC	Regional Center
RHC	Rural Health Clinic
RPD	Restricted Provider Database
RSS	Risk Stratification and Segmentation
SABIRT	Screening, Assessment, Brief Intervention, and Referral to Treatment
SDOH	Social Drivers of Health
SED	Serious Emotional Disturbance
SFTP	Secure File Transfer Protocol
SMHS	Specialty Mental Health Services
SMI	Serious Mental Illness
SNF	Skilled Nursing Facility
SPD	Senior and Person with Disability
STC	Special Terms and Conditions
STD	Sexually Transmitted Disease
SUD	Substance Use Disorder
TAR	Treatment Authorization Request
TB	Tuberculosis
TCM	Targeted Case Management
TDD	Telecommunication Devices for the Deaf
TNE	Tangible Net Equity
TPTL	Third Party Tort Liability
TTY	Telephone Typewriters
U.S. DHHS	United States Department of Health and Human Services
UM	Utilization Management
US DOJ	United States Department of Justice
USC	United States Code

Acronyms	Corresponding Terms
USPSTF	United States Preventive Services Task Force
VFC	Vaccines for Children
W&I	Welfare and Institutions Code
WCM	Whole Child Model
WIC	Women, Infants and Children Supplemental Nutrition Program

Exhibit A, ATTACHMENT II

1.0 Operational Readiness Deliverables and Requirements

This Article describes a non-exhaustive list of Contractor deliverables, activities, and timeframes to be completed during the Implementation Period before beginning the Operations Period.

Upon successful completion of operational readiness deliverables and requirements, DHCS will provide Contractor a written authorization to begin its Operations Period. The Implementation Period begins with the effective date of the Contract and extends to the beginning of the Operations Period.

Once the Contract is awarded, DHCS will provide Contractor with a timeline to complete Implementation Period deliverables and requirements. The table in this Article must not be deemed as exhaustive, exclusive, or limiting. Contractor must submit all required operational deliverables consistent with all requirements set forth in this Contract on a schedule, form, and manner specified by DHCS. Contractor may be responsible for additional deliverable requirements or activities during the Implementation Period based on changes in State and federal law and/or DHCS program needs. Contractor must comply with any additional requirements, not listed in the tables below, upon DHCS' request and in the form and manner specified by DHCS.

In the event Contractor fails to submit all deliverables in accordance with the milestones and timeframes required by DHCS, DHCS may impose Liquidated Damages and Sanctions in accordance with Exhibit E, Sections 1.1.19 (*Sanctions*) and 1.20 (*Liquidated Damages*).

Dual Special Needs Plan

Contractors located in counties that had previously participated in the Coordinated Care Initiative (Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara counties) must have a Dual Special Needs Plan (D-SNP) available to dual eligible Members for contract year 2025.

EXHIBIT A, ATTACHMENT I – 1.0 DEFINITIONS

No deliverables listed for this Article.

EXHIBIT A, ATTACHMENT I – 2.0 ACRONYMS

No deliverables listed for this Article.

EXHIBIT A, ATTACHMENT II – 1.0 OPERATIONAL READINESS DELIVERABLES AND REQUIREMENTS

See specific contract Sections below for details.

EXHIBIT A, ATTACHMENT III – 1.1 PLAN ORGANIZATION AND ADMINISTRATION

Identifier	Operational Readiness Requirement
R.0001	Submit documentation of State employees (current and former) who may present a conflict of interest as defined in Exhibit A, Attachment III, Subsection 1.1.3 (*Conflict of Interest – Current and Former State Employees)*.
R.0002	Submit a complete organizational chart.
R.0003	If Contractor is a subsidiary organization, submit an attestation by the parent organization that this Contract will be a high priority to the parent organization.
R.0004	Submit an attestation that the medical decisions made by the medical director will not be unduly influenced by fiscal or administrative management.
R.0005	Submit policies and procedures describing the representation and participation of Medi-Cal Members on Contractor's public policy advisory committee.
R.0006	Submit the Knox-Keene license exhibits and forms reflecting current operation status, as specified in Exhibit A, Attachment III, Section 1.1 (*Plan Organization and Administration*) and 28 California Code of Regulations (CCR) section 1300.51.
R.0007	Submit supporting documentation if Contractor is not currently licensed to operate in an awarded Service Area, as specified in Exhibit A, Attachment III, Section 1.1 (*Plan Organization and Administration*).
R.0008	If, within the last five years, Contractor has had a contract terminated or not renewed for poor performance, nonperformance, or any other reason, Contractor must submit a summary of the circumstances surrounding the termination or non-renewal, a description of the parties involved, including address(es) and telephone number(s). Describe Contractor's Corrective Actions to prevent future occurrences of any problems identified.
R.0009	Identify the composition and meeting frequency of any committee participating in establishing Contractor's public policy including the percent of patient/Member consumers. Describe Contractor's Governing Board, including the percent of patient/Member consumers, the frequency of the committee's report submission to Contractor's Governing Board, and the Governing Board's process for handling reports and recommendations after receipt.
R.0010	Contractor must submit policies and procedures for ensuring that all appropriate staff and Network Providers receive biennial diversity, Health Equity, and inclusion training (sensitivity, diversity, communication skills, and cultural competency/humility training) relating to Members including completion of required Continuing Medical Education on cultural competency/humility and implicit bias.

EXHIBIT A, ATTACHMENT III – 1.2 FINANCIAL INFORMATION

Identifier	Operational Readiness Requirement
R.0012	Submit most recent audited annual financial reports.
R.0013	Submit quarterly Financial Statements with the most recent quarter prior to execution of the Contract.
R.0014	Submit the Knox-Keene license exhibits reflecting projected financial viability as specified in Exhibit A, Attachment III, Section 1.2 (*Financial Information*) and 28 CCR section 1300.76.
R.0015	Submit Knox-Keene license Exhibit HH-6 as specified in Exhibit A, Attachment III, Section 1.2 (*Financial Information*) and 28 CCR section 1300.51(d)(HH).
R.0016	1) Describe any risk sharing or Incentive Arrangements. 2) Explain any intent to enter into a stop loss option with DHCS. 3) Describe any reinsurance and risk-sharing arrangements with any Subcontractors and Downstream Subcontractors shown in this Contract. 4) Submit copies of all policies and agreements. 5) Comply with assumption of financial risk and reinsurance requirements pursuant to 22 CCR sections 53863 and 53868. Comply with directed payments requirements pursuant to 42 Code of Federal Regulations (CFR) section 438.6.
R.0017	Fiscal Arrangements: Submit the Knox-Keene license exhibits as described in Exhibit A, Attachment III, Section 1.2 (*Financial Information*) and in 28 CCR section 1300.51.
R.0018	Describe systems for ensuring that Subcontractors, Downstream Subcontractors, and Network Providers who are providing services to Medi-Cal Members, have the administrative and financial capacity to meet its contractual obligations and requirements, as described in Exhibit A, Attachment III, Section 1.2 (*Financial Information*) and in 22 CCR section 53250 and 28 CCR section 1300.70.
R.0019	Submit financial policies that relate to Contractor's systems for budgeting and operations forecasting. The policies should include comparison of actual operations to budgeted operations, timelines used in the budgetary process, number of years prospective forecasting is performed, and variance analysis and follow-up procedures.
R.0020	Describe process to ensure timely filing of required financial reports as described in Exhibit A, Attachment III, Section 1.2 (*Financial Information*). Contractor must also describe how it will comply with the Administrative Cost requirements referenced in 22 CCR section 53864(b).
R.0021	Provide letters of financial support, credit, bond, or loan guarantee or other financial guarantees, if any, in at least the same amount that the obligations to Members will be performed.

EXHIBIT A, ATTACHMENT III – 1.3 PROGRAM INTEGRITY AND COMPLIANCE PROGRAM

Identifier	Operational Readiness Requirement
R.0022	Submit a Compliance Program, Standard of conduct or code of conduct, related policies and procedures, and training materials.
R.0023	Organizational chart for the Compliance Program showing key personnel.
R.0024	Submit a Fraud Prevention Program and related policies and procedures, training materials, and an organizational chart showing key personnel.
R.0025	Submit policies and procedures for the screening, Enrollment of Network Providers, if Contractor elects to screen and enroll.

EXHIBIT A, ATTACHMENT III – 2.1 MANAGEMENT INFORMATION SYSTEM

Identifier	Operational Readiness Requirement
R.0026	Submit a completed MCO Baseline Assessment Form.
R.0027	If procuring a new Management and Information System (MIS) or modifying a current system, Contractor must provide a detailed implementation plan that includes the following: 1) Outline of the tasks required; 2) The major milestones; and 3) The responsible party for all related tasks. In addition, the implementation plan must also include: 1) A full description of the acquisition of software and hardware, including the schedule for implementation; 2) Full documentation of support for software and hardware by the manufacturer or other contracted party; 3) System test flows through a documented process that has specific control points where evaluation data can be utilized to correct any deviations from expected results; and 4) Documentation of system changes related to Exhibit G, (*Business Associate Addendum*) requirements.
R.0028	Submit a detailed description, including a diagram and/or flow chart, of how Contractor will monitor the flow of Encounter Data, Network Provider Data, Program Data, Template Data, and all other data required by this Contract from origination at the Provider level to Contractor, through submission to DHCS as well as how Contractor will transmit information regarding general and specific data quality issues identified by DHCS from origination to Providers for correction.
R.0029	Submit Encounter Data, Provider data, Program Data, and Template Data test files as required by DHCS, produced using real or proxy data processed by a new or modified MIS to DHCS. Production data submissions from a new or modified MIS may not take place until this test has been successfully reviewed and approved by DHCS.

Identifier	Operational Readiness Requirement
R.0030	Submit policies and procedures for the submission of complete, accurate, reasonable and timely Encounter Data, Provider data, Program Data, Template Data, and all other data required by this Contract, including how Contractor will correct data quality issues identified by DHCS.
R.0032	Submit the data security, backup, or other data disaster processes used in the event of a MIS failure.
R.0033	Submit a detailed description, including details regarding interoperability, of the proposed and/or existing MIS as it relates to each of the subsystems described in Exhibit A, Attachment III, Section 2.1 (*Management Information System*).
R.0246	Submit policies and procedures to demonstrate how Contractor will conduct routine testing and monitoring, and update their systems as appropriate to ensure the Application Programming Interfaces (APIs) are functioning properly and complying with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements.

EXHIBIT A, ATTACHMENT III – 2.2 QUALITY IMPROVEMENT AND HEALTH EQUITY TRANSFORMATION PROGRAM

Identifier	Operational Readiness Requirement
R.0035	Submit a flow chart and/or organization chart identifying all components of the Quality Improvement and Health Equity Transformation Program (QIHETP) including who is involved and responsible for each activity.
R.0036	Submit a flow chart and/or organization chart identifying all components of the QIHETP including who is involved and responsible for each activity, for each Fully Delegated Subcontractor, and each health plan downstream Subcontractor.
R.0037	Submit policies that specify the responsibility of the Governing Board in the QIHETP.
R.0038	Submit policies for the Quality Improvement and Health Equity Committee (QIHEC) including membership, activities, roles and responsibilities and reporting relationships to other committees within the organization.
R.0039	Submit policies for each Fully Delegated Subcontractor's and health plan Downstream Subcontractor's QIHEC including membership, activities, roles and responsibilities, and reporting relationships to other committees within the organization.
R.0040	Submit procedures outlining how Providers, health plan Subcontractors, and health plan Downstream Subcontractors will participate in the QIHETP and Population Needs Assessment (PNA) and how the findings from both will be shared with Providers, health plan Subcontractors and health plan Downstream Subcontractors.

Identifier	Operational Readiness Requirement
R.0041	Submit policies and procedures related to the oversight of Subcontractors and Downstream Subcontractors for any delegated QIHETP activities, including a complete list of all Subcontractors, Downstream Subcontractors, and their delegated QIHETP activities.
R.0042	Submit policies and procedures that describe how Contractor will develop and submit an annual QIHETP Plan that provides a comprehensive assessment of all Quality Improvement (QI) and Health Equity activities undertaken, including an evaluation of the effectiveness of QI and Health Equity interventions, and an assessment of all Subcontractors' performance for any delegated QI and/or Health Equity activities.
R.0043	Submit policies and procedures to address how Contractor will meet each of the following requirements: 1) Quality and Health Equity Performance Measure annual reporting requirements; 2) Meet or exceed DHCS established Quality and Health Equity Performance measure benchmarks; 3) Ensure all Fully Delegated Subcontractors meet or exceed DHCS established Quality and Health Equity Performance measure benchmarks; 4) Performance Improvement Projects; 5) Consumer Satisfaction Survey; 6) Network Adequacy Validation; 7) Encounter Data Validation; 8) Focused Studies; and 9) Technical Assistance Recommendations.
R.0044	Submit policies and procedures for reporting any disease or condition to public health authorities.
R.0045	Submit policies and procedures for Credentialing and recredentialing that ensure all Network Providers who deliver Covered Services to Members are qualified in accordance with applicable standards and are licensed, certified, or registered, as appropriate.
R.0046	No later than January 1, 2024, submit either (A) or (B and C): A. Evidence of National Committee for Quality Assurance (NCQA) Health Plan Accreditation. B. Timeline that demonstrates the NCQA Health Plan Accreditation process will be started no later than January 1, 2024, and full NCQA Health Plan Accreditation will be received no later than January 1, 2026. C. Evidence of interim NCQA Health Plan Accreditation approval within five Working Days of receipt.

Identifier	Operational Readiness Requirement
R.0047	No later than January 1, 2024, submit either (A) or (B): A. Evidence of NCQA Health Equity Accreditation. B. Timeline that demonstrates the NCQA Health Equity Accreditation process will be started no later than January 1, 2024, and completed no later than January 1, 2026.
R.0048	Submit policies and procedures for identifying, evaluating, and reducing Health Disparities.
R.0049	Submit policies and procedures that describe how Contractor ensures the adoption, dissemination and monitoring of the use of clinical practice guidelines.
R.0050	Submit policies and procedures that describe the integration of Utilization Management into the QIHETP.
R.0051	Submit policies and procedures that describe how Contractor will detect both over- and under-utilization of services, including outpatient Prescription Drugs.
R.0052	Submit policies and procedures that describe how Contractor will ensure the provision of all screening, preventive and Medically Necessary diagnostic and treatment services provided for Members less than 21 years of age, and how Contractor will identify and address underutilization of preventive services for such Members.
R.0053	Submit policies and procedures that describe how Contractor will promote Early and Periodic Screening, Diagnostic and Treatment (EPSDT) and preventive services to Members less than 21 years of age, as well as outreach to Members less than 21 years of age overdue for such services.
R.0055	Submit a description of a comprehensive wellness program for Members less than 21 years of age.
R.0056	Submit policies and procedures that describe how Contractor will maintain and continually monitor, evaluate, and improve Cultural and Linguistic (C&L) services that support the delivery of Covered Services to Members less than 21 years of age.
R.0057	Submit policies and procedures that describe how Contractor will develop and maintain a school-linked statewide Network of School Site Behavioral Health counselors.
R.0058	Submit policies and procedures that describe how Contractor will inform its Network Providers about the Vaccines for Children (VFC) program and how they will promote and support Enrollment of appropriate Providers in VFC.
R.0059	Submit policies and procedures that describe Contractor's Member and family engagement strategy and how Members and/or parents and caregivers are engaged in the development of QI and Health Equity activities and interventions.
R.0060	Submit policies and procedures that describe how Contractor will engage with local entities when developing interventions and strategies to address deficiencies in performance measures related to Members less than 21 years of age.

Identifier	Operational Readiness Requirement
R.0061	Submit policies and procedures that describe how Contractor will ensure the provision of all Medically Necessary mental health and Substance Use Disorder (SUD) services to Members less than 21 years of age.

EXHIBIT A, ATTACHMENT III – 2.3 UTILIZATION MANAGEMENT PROGRAM

Identifier	Operational Readiness Requirement
R.0062	Submit written description of Utilization Management (UM) program that describes appropriate processes to be used to review, approve, modify, deny, and delay the provision of medical, mental health, and SUD services to demonstrate compliance with mental health parity.
R.0063	Submit written description of procedures for reviews and annual updates of UM program.
R.0064	Submit written description of Grievances and Appeals procedures for Providers and Members that will be published on Contractor's website.
R.0065	Submit policies and procedures for Standing Referrals.
R.0066	Submit policies and procedures on Standing Referrals when a Member condition requires a specialized medical care over a prolonged period of time.
R.0067	Submit policies and procedures for Prior Authorization, concurrent review, and Retrospective Review.
R.0068	Submit a list of services requiring Prior Authorization and the Utilization Review criteria.
R.0069	Submit policies and procedures for the Utilization Review Appeals process for Providers and Members.
R.0070	Submit policies and procedures that specify timeframes for medical authorization.
R.0072	Submit policies and procedures to detect both under- and over-utilization of health care services.
R.0073	Submit policies and procedures showing how UM functions which may be delegated to a Subcontractor or Downstream Subcontractor will be regularly evaluated for compliance with Contract requirements and, that any issues identified through the UM program are appropriately resolved; and that UM activities are properly documented and reported.
R.0074	Submit policies and procedures to refer Members who are potentially eligible for Multipurpose Senior Service Program (MSSP) services to MSSP services Providers for authorization.

EXHIBIT A, ATTACHMENT III – 3.1 NETWORK PROVIDER AGREEMENTS, SUBCONTRACTOR AGREEMENTS, DOWNSTREAM SUBCONTRACTOR AGREEMENTS, AND CONTRACTOR'S OVERSIGHT DUTIES

Identifier	Operational Readiness Requirement
R.0075	Submit policies and procedures for a system to evaluate and monitor the financial viability of all Network Providers, Subcontractors, and Downstream Subcontractors.
R.0076	Submit executed Network Provider Agreements/Subcontractor Agreements/Downstream Subcontractor Agreements or documentation substantiating Contractor's efforts to enter into these agreements with the Local Health Department (LHD) for each of the following public health services: 1) Family Planning Services; 2) Sexually Transmitted Disease (STD) Services; 3) Human Immunodeficiency Virus (HIV) testing and counseling; and 4) Immunizations.
R.0244	Submit all Network Provider, Subcontractor, and Downstream Subcontractor Agreements templates.
R.0245	Submit Subcontractor and Downstream Subcontractor Agreement templates language showing accountability of any delegated QIHETP functions and responsibilities.

EXHIBIT A, ATTACHMENT III – 3.2 PROVIDER RELATIONS

Identifier	Operational Readiness Requirement
R.0077	Submit policies and procedures for the Provider Dispute Resolution Mechanism.
R.0078	Submit a written description of how Contractor will communicate the Provider Dispute Resolution Mechanism to Network Providers, out-of-Network Providers, Subcontractors, and Downstream Subcontractors.
R.0079	Submit protocols for payment and communication with out-of-Network Providers.
R.0080	Submit policies and procedures for ensuring out-of-Network Providers receive Contractor's clinical protocols and evidence-based practice guidelines.
R.0081	Submit copy of Contractor's Provider manual.
R.0082	Submit a schedule of Network Provider training to be conducted during year one of operation. Include date, time and location, and complete curriculum.
R.0083	Submit policies and procedures for ensuring Network Providers receive training within the required timeframes, regarding clinical protocols, evidenced-based practice guidelines, and DHCS developed cultural awareness and sensitivity instruction for Senior and Person with Disability (SPD) Members.
R.0084	Submit protocols for communicating and interacting with emergency departments in and out of Contractor's Service Area.

EXHIBIT A, ATTACHMENT III – 3.3 PROVIDER COMPENSATION ARRANGEMENTS

Identifier	Operational Readiness Requirement
R.0085	Submit policies and procedures regarding timing of Capitation Payments to Primary Care Providers (PCP) or clinics.
R.0086	Submit description of any Provider financial incentive programs including, but not limited to, Physician incentive plans as defined in 42 CFR section 422.208.
R.0087	Submit description of efforts to promote value-based models and investments in Primary Care using the Health Care Payment Learning and Action Network Alternative Payment Model (HCP LAN APM) Framework as outlined in the Alternative Payment Model (APM) Framework White Paper, https://hcp-lan.org/workproducts/apm-whitepaper.pdf.
R.0088	Submit policies and procedures for processing and payment of claims.
R.0089	Submit policies regarding the prohibition of a claim or demand for services provided under the Medi-Cal managed care contract to any Member.
R.0090	Submit any Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) Network Provider Agreements to DHCS for approval.
R.0091	Submit policies and procedures for the reimbursement of non-contracting Certified Nurse Midwives (CNMs) and Nurse Practitioners (NPs).
R.0092	Submit policies and procedures for the reimbursement of Skilled Nursing Facilities and Nursing Facilities (SNF/NF).
R.0093	Submit policies and procedures for the reimbursement to LHDs and non-contracting family planning Providers for the provision of family planning services, STD episode, and HIV testing and counseling.
R.0094	Submit policies and procedures for the reimbursement of immunization services to LHD.
R.0095	Submit policies and procedures regarding payment to non-contracting Emergency Services Providers. Include reimbursement schedules for all non-contracting Emergency Service Providers, including any schedule of per diem rates and/or Fee-for-Service (FFS) Rates for each of the following Provider types: 1) PCPs; 2) Medical Groups and Independent Practice Associations; 3) Specialists; and 4) Hospitals.
R.0096	Submit policies and procedures for reporting Provider-Preventable Conditions.
R.0247	Submit policies and procedures for pre-payment and post-payment claims review.

EXHIBIT A, ATTACHMENT III – 4.1 MARKETING

Identifier	Operational Readiness Requirement
R.0097	Submit policies and procedures for training and certification of Marketing Representatives.
R.0098	Submit a description of training program, including the Marketing Representative's training/certification manual.
R.0099	Submit Contractor's Marketing plan.
R.0100	Submit copy of boilerplate request form used to obtain DHCS approval of participation in a Marketing event.

EXHIBIT A, ATTACHMENT III – 4.2 ENROLLMENTS AND DISENROLLMENTS

Identifier	Operational Readiness Requirement
R.0101	Submit policies and procedures for how Contractor will update and maintain accurate information on its contracting Providers.
R.0102	Submit policies and procedures for how Contractor will access and utilize Enrollment data from DHCS.
R.0103	Submit policies and procedures relating to Member disenrollment.

EXHIBIT A, ATTACHMENT III – 4.3 POPULATION HEALTH MANAGEMENT AND COORDINATION OF CARE

Identifier	Operational Readiness Requirement
R.0108	Submit evidence illustrating Contractor's MIS has the capacity to meet DHCS data integration and exchange requirements as outlined in Exhibit A, Attachment III, Subsection 4.3.3 (*Data Integration and Exchange*).
R.0110	Submit policies and procedures for complying with the Risk Stratification/Segmentation (RSS) requirements in Exhibit A, Attachment III, Subsection 4.3.5 (*Population Risk Stratification and Segmentation, and Risk Tiering*).
R.0111	Submit Contractor's process(es) describing how Contractor identifies Significant Changes in Members' health status or level of care and how Contractor monitors to ensure appropriate re-stratification.
R.0112	Submit a list of the data used by Contractor's RSS approach that includes the required sources in Exhibit A, Attachment III, Subsection 4.3.5.A.5 (*Population Risk Stratification and Segmentation, and Risk Tiering*) at a minimum. For each type of data listed, Contractor must include a description of the data and its origin, and how the data will be incorporated into the RSS approach.
R.0113	Submit a description of Contractor's population RSS and Risk Tiering approach, as well as the processes for how RSS and Risk Tiers are used to connect Members to appropriate services.
R.0114	Submit the method of bias analysis used to analyze Contractor's RSS and Risk Tiering approach, and the analysis of whether any biases were identified and if so, how they were corrected.

Identifier	Operational Readiness Requirement
R.0115	Submit policies and procedures for conducting an initial screening or assessment of each Member's needs within 90 days of Enrollment, for sharing that information with DHCS, other Contractors, or Providers on behalf of Members, as appropriate, and for monitoring the completion of the assessments.
R.0116	Submit a description of Contractor's Complex Care Management (CCM) program outlining the types of Members, populations and/or program criteria established, the CCM program's approach for both long-term chronic conditions and episodic, temporary interventions, and processes for fulfilling all the other CCM program requirements outlined in Exhibit A, Attachment III, Subsection 4.3.7.A.2 (*Care Management Programs*).
R.0117	Submit policies and procedures for handling care management, and the non-duplication of services when multiple Subcontractors, Downstream Subcontractors, and/or Providers are involved in a Member's care.
R.0118	Submit policies and procedures for assigning Care Managers to Members, and monitoring to ensure all Care Managers' responsibilities are fulfilled.
R.0119	Submit policies and procedures for documenting and maintaining Care Management Plans (CMPs).
R.0120	Submit policies and procedures that meet the Basic PHM requirements outlined in Exhibit A, Attachment III, Subsection 4.3.8.A (*Basic Population Health Management*). Contractor's policies and procedures should address core Basic PHM, Care Coordination, care navigation and referral needs of all Members. Contractor's policies and procedures must also address requirements regarding wellness and prevention programs and chronic disease management programs.
R.0121	Submit evidence that Contractor is providing the Provider resources as required by Exhibit A, Attachment III, Subsection 4.3.8.B (*Basic Population Health Management*).
R.0122	Submit policies and procedures for identifying, referring, and providing EPSDT case management services for Members less than 21 years of age.
R.0123	Submit policies and procedures for identifying and providing care management services for Children and Youth with Special Health Care Needs (CYSHCN).
R.0124	Submit policies and procedures for identifying, referring, and providing care management services for Members at risk of developmental delay and eligible to receive services from the local Early Start Program.
R.0125	Submit policies and procedures for the provision of comprehensive wellness and prevention programs to all Members.
R.0126	Submit policies and procedures for providing Transitional Care Services as outlined in Exhibit A, Attachment III, Subsection 4.3.11.A (*Targeted Case Management Services*).
R.0127	Submit Contractor's standardized discharge risk assessment that identifies Members' risk for re-hospitalization, re-institutionalization, and substance use recidivism.

Identifier	Operational Readiness Requirement
R.0128	Submit Contractor's strategy for developing policies and procedures for Discharge Planning and Transitional Care Services with each Network and out-of-Network Provider hospital within its Service Area(s).
R.0129	Submit policies and procedures for ensuring Discharge Planning documents are completed, and that the documents fulfill the requirements outlined in Exhibit A, Attachment III, Subsection 4.3.11.B (*Targeted Case Management Services*), and are provided to Members, parents, legal guardians, or Authorized Representatives (AR) when being discharged from a hospital, institution, or facility.
R.0131	Submit policies and procedures for coordinating care for Members who may need or are receiving services and/or programs from out-of-Network Providers.
R.0132	Submit policies and procedures for identifying and referring the target populations for Targeted Case Management (TCM) programs within Contractor's Service Area(s) and for reaching out to Local Government Agencies (LGAs) to coordinate care, as appropriate, upon notification from DHCS that Members are receiving TCM services. Policies and procedures must include processes for ensuring non-duplicative services.
R.0133	Submit policies and procedures for identifying, referring, and coordinating care for Members in need of Non-Specialty Mental Health Services (NSMHS), Specialty Mental Health Services (SMHS) and/or SUD treatment services with Contractor's Network, the County Mental Health Plan (MHP), Drug Medi-Cal Organized Delivery System (DMC-ODS) or Drug Medi-Cal, or other community resources. Contractor is required to use the State-approved screening and transition tools.
R.0134	Submit policies and procedures for identifying, referring, and coordinating care for Members requiring alcohol or SUD treatment services from both within and, if necessary, outside Contractor's Service Area(s) in partnership with the LGAs responsible for such services.
R.0135	Submit policies and procedures for identifying, referring, and coordinating care for Members with the local California Children's Services (CCS) Program.
R.0136	Submit policies and procedures for the identifying, referring, and coordinating care for Members with Developmental Disabilities (DD) in need of non-medical services from the local Regional Center (RC) that includes the duties of the RC liaison.
R.0137	Submit policies and procedures for ensuring Care Coordination of Local Education Agency (LEA) services, including PCP involvement in the development of the Member's Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP).

Identifier	Operational Readiness Requirement
R.0138	Submit policies and procedures for identifying, referring, and ensuring Care Coordination and non-duplication of services for Members who are eligible for or who are already receiving contracted school-based services, such as EPSDT and Behavioral Health Services, from either LEAs, FQHCs or community-based organizations.
R.0139	Submit policies and procedures for providing required dental services and dental-related services that includes the duties of Contractor's dental liaison.
R.0140	Submit policies and procedures for ensuring case management and Care Coordination of Members with the LHD Tuberculosis (TB) Control Officer. Policies and procedures must include assessing and referring Members with active TB and at risk of non-compliance with TB drug therapy to the LHD.
R.0141	Submit policies and procedures for identifying and referring eligible Members for Women, Infants and Children Supplemental Nutrition Program (WIC) services.
R.0142	Submit policies and procedures for identifying and referring eligible Members to Home and Community-Based Services (HCBS) programs. Policies and procedures must include processes for ensuring non-duplicative services.
R.0143	Submit policies and procedures for identifying and referring eligible Members to the county In-Home Supportive Services (IHSS) program, the duties of Contractor's IHSS liaison. and ensure compliance with the requirements outlined in Exhibit A, Attachment III, Subsection 4.3.21 (*In-Home Supportive Services*).
R.0144	Submit policies and procedures that described the duties and responsibilities of Contractor's Indian Health Care Provider (IHCP) tribal liaison in working with IHCPs within Contractor's Service Area(s).
R.0248	Submit policies and procedures that describe the duties and responsibilities of Contractor's managed care liaisons, including training and notification requirements for each of the following required liaisons: 1) Long-Term Services and Supports (LTSS) Liaison; 2) Transportation Liaison; 3) CCS Liaison; and 4) County Child Welfare Liaison.

EXHIBIT A, ATTACHMENT III – 4.4 ENHANCED CARE MANAGEMENT

Identifier	Operational Readiness Requirement
R.0145	Submit an Enhanced Care Management (ECM) Model of Care (MOC) using the DHCS approved template. If Contractor has a previously approved MOC for implementation of ECM effective January 1, 2022, or July 1, 2022, Contractor may submit an attestation stating that there are no changes to the previously approved MOC. If Contractor has changes to a previously approved MOC, Contractor must submit an updated MOC with all changes in track-edits for DHCS review and approval. Contractor must submit to DHCS any Significant Changes to its MOC for DHCS review and approval at least 60 calendar days in advance of any occurrence of changes or updates, pursuant to Exhibit A, Attachment III, Subsection 4.4.5.D (*Enhanced Care Management Model of Care*) and in accordance with DHCS policies and guidance, including All Plan Letters (APLs). Significant Changes may include, but are not limited to, changes to Contractor's approach to administer or deliver ECM services, approved policies and procedures, and Subcontractor Agreements and Downstream Subcontractor Agreements boilerplates.

EXHIBIT A, ATTACHMENT III – 4.5 COMMUNITY SUPPORTS

Identifier	Operational Readiness Requirement
R.0146	Submit a Community Supports MOC using the DHCS approved template. If Contractor has a previously approved MOC for implementation of Community Supports effective January 1, 2022, or July 1, 2022, Contractor may submit an attestation stating that there are no changes to the previously approved MOC. If Contractor has changes to a previously approved MOC, Contractor must submit an updated MOC with all changes in track-edits for DHCS review and approval. Contractor must submit to DHCS any changes to its MOC for DHCS review and approval at least 60 calendar days in advance of any occurrence of changes or updates, pursuant to Exhibit A, Attachment III, Subsection 4.5.6.D (*Community Supports Model of Care*) and in accordance with DHCS policies and guidance, and APLs. Substantial changes may include, but are not limited to, changes to Contractor's approach to administer or deliver Community Supports services; approved policies and procedures; and Network Provider Agreement, Subcontractor Agreements, or Downstream Subcontractor Agreements boilerplates, as appropriate.

EXHIBIT A, ATTACHMENT III – 4.6 MEMBER GRIEVANCE AND APPEAL SYSTEM

Identifier	Operational Readiness Requirement
R.0147	Submit policies and procedures relating to Contractor's Member Grievance and Appeal system including compiling, aggregating, and reviewing Grievance and Appeal data.

Identifier	Operational Readiness Requirement
R.0148	Submit policies and procedures for Contractor's oversight of the Member Grievance and Appeal system for the receipt, processing and distribution of Grievance and Appeals, including the expedited review of Appeals. Include a flow chart to demonstrate the process.
R.0149	Submit policies and procedures relating to Contractor's Grievances and the expedited review of Grievances as required by 42 CFR sections 438.402, 438.406, and 438.408, 28 CCR sections 1300.68 and 1300.68.01, and 22 CCR section 53858.
R.0150	Submit policies and procedures relating to the resolution of Discrimination Grievances.
R.0151	Submit policies and procedures relating to Contractor's Appeals process. Include Contractor's responsibilities in State Hearings, Independent Medical Review, and expedited Appeals.
R.0152	Submit format for monthly Grievance and Appeal report.

EXHIBIT A, ATTACHMENT III – 5.1 MEMBER SERVICES

Identifier	Operational Readiness Requirement
R.0153	Submit policies and procedures that address Member's rights and responsibilities. Include method for communicating them to both Members and Providers.
R.0154	Submit policies and procedures for training Contractor's Member Services staff on Member rights, responsibilities, and services available under this Contract.
R.0155	Submit policies and procedures for training Contractor's Network Providers, Subcontractors, and Downstream Subcontractors on Member rights, Covered Services, and other responsibilities.
R.0156	Submit policies and procedures for handling Member Grievances not related to an Adverse Benefit Determination (ABD).
R.0157	Submit policies and procedures for providing communication access to Members in alternative formats or through other methods that ensure communication, including assistive listening systems, sign language interpreters, captioning, written communication, electronic format, plain language or written translations and oral interpreters, including Limited English Proficiency (LEP) Members, or non-English speaking.
R.0158	Submit policies and procedures regarding compliance with the Americans with Disabilities Act of 1990 (42 United States Code (USC) section 12101 et seq.), Section 504 of the Rehabilitation Act of 1973 (29 USC section 794), Section 1557 of the Patient Protection and Affordable Care Act (42 USC section 18116), SB 223 (Atkins, Chapter 771, Statutes of 2017), and SB 1423 (Hernandez, Chapter 568, Statutes of 2018), and Government Code(GC) section 11135, as required in APL 21-011.

Identifier	Operational Readiness Requirement
R.0159	Submit the following consistent with the requirements of Exhibit E, Section 1.1.23 (*Confidentiality of Information*). Submit policies addressing Member's rights to confidentiality of medical information. Include procedures for release of medical information and the right to amend or correct Medical Records pursuant to 45 CFR sections 164.524 and 164.526.
R.0160	Submit policies and procedures for addressing Advance Directives.
R.0161	Submit policies and procedures for the training of Member services staff.
R.0162	Submit policies and procedures regarding the development content and distribution of Member information. Address appropriate reading level and translation of materials.
R.0163	Submit final approved Member Identification Card and Member Handbook.
R.0164	For non-COHS Contractors, submit policies and procedures explaining the Member's right to an Independent Medical Review (IMR) including when an expedited IMR is available to the Member.
R.0165	Submit policies and procedures explaining the Member's right to a State Hearing after receiving a Notice of Appeal Resolution or in cases of Deemed Exhaustion. These policies and procedures must also include the information on the Member's right to an expedited State Hearing if his/her health condition is in jeopardy.
R.0166	Submit policies and procedures and live notice Contractor will send to Members advising them of how to obtain Member informing materials including the Member Handbook, and Provider Directory.
R.0167	Submit policies and procedures on the Member's right to disenroll at any time to enroll in another Medi-Cal Managed Care Plan pursuant to 22 CCR section 53891(c).
R.0168	Submit policies and procedures for notifying Members of changes in availability or location of Covered Services.
R.0169	Submit policies and procedures for Member selection of a PCP or non-physician medical practitioner. Include the mechanism used for allowing SPD Members to request a Specialist to serve as their PCP.
R.0170	Submit policies and procedures for Member Assignment to a PCP. Include the use of FFS utilization data and other data in linking a SPD to a PCP, or Specialist acting as the SPD's PCP.
R.0171	Submit policies and procedures for notifying the PCP that a Member has selected or has been assigned to within ten calendar days from the selection or assignment.
R.0172	Submit policies and procedures demonstrating how, upon entry into Contractor's Network, the relationship between Traditional and Safety-Net Providers and the Member is not disrupted, to the maximum extent possible.
R.0173	Submit policies and procedures for notifying Members of an ABD for denial, deferral, or modification of requests for Prior Authorization, including explanation of Deemed Exhaustion to the Member.

Identifier	Operational Readiness Requirement
R.0249	Submit policies and procedures to demonstrate how, for dates of service on or after January 1, 2016, Contractor will make the data it maintains available within one Working Day of receipt data or information, or one Working Day after a claim is adjudicated or Encounter Data is received.
R.0250	Submit policies and procedures to demonstrate how Contractor will update its Provider Directory API at least weekly after receiving updated Provider information or being notified of any information that affects the content or accuracy of the Provider Directory.
R.0251	Submit a hard copy of the patient access API and Provider Directory API documentation and the publicly accessible link or web URL where each API is located. The documentation must be accessible without any preconditions to access, and contents must include at a minimum the following information: 1) API syntax, function names, required and optional parameters supported and their data types, return variables and their types/structures, exceptions and exception handling methods and their returns; 2) The software components and configurations an application must use to successfully interact with the API and process its response(s); and 3) All applicable technical requirements and attributes necessary for an application's registration with any authorized server(s) deployed in conjunction with the API.
R.0252	Submit a hard copy and a link to Contractor's publicly accessible Member educational resources that will achieve the following: 1) Demonstrate the steps Member may consider taking to help protect the privacy and security of their health information and the importance of understanding the security and privacy practices of any application to which they entrust their health information; and 2) Provide an overview of which types of organizations or individuals are and are not likely to be HIPAA covered entities, the oversight responsibilities of the Office for Civil Rights (OCR) and the Federal Trade Commission (FTC), and how to submit a complaint to OCR and FTC.

EXHIBIT A, ATTACHMENT III – 5.2 NETWORK AND ACCESS TO CARE

Identifier	Operational Readiness Requirement
R.0174	Submit policies and procedures on how Contractor will assist Members in selecting PCPs who are accepting new patients and how it will afford access to Primary Care and specialty care.
R.0175	Submit complete 274 Provider File demonstrating the ability to serve 60 percent of Potential Members, including SPD Members, in each of the counties that Contractor serves pursuant to this Contract.

Identifier	Operational Readiness Requirement
R.0176	Submit policies and procedures for how Contractor will meet federal requirements for access and reimbursement Network and/or out-of-Network FQHC, RHC, Freestanding Birthing Center (FBC) services, CNMs, and Licensed Midwives (LMs).
R.0177	Submit policies and procedures that establish traditional and Safety-Net Provider participation standards.
R.0178	Submit policies and procedures describing how Contractor will monitor Provider to Member ratios to ensure they are within specified standards.
R.0179	Submit policies and procedures regarding Physician supervision of non-physician medical practitioners.
R.0180	Submit policies and procedures to monitor and ensure how Contractor, Network Providers, Subcontractors and Downstream Subcontractors comply with timely access requirements for each of the following: 1) Standards for timely appointments; 2) Appropriate clinical timeframes; 3) Shortening or expanding timeframes; 4) Follow up appointments; 5) Triaging Member calls; 6) Telephone interpreters; and 7) Contractor's customer service line.
R.0181	Submit policies and procedures for how Contractor will ensure Network Provider hours of operation are no less than the hours of operation offered to other commercial or FFS recipients.
R.0182	Submit a policy regarding the availability of Contractor's Medi-Cal director or licensed Physician 24 hours a day, seven days a week, and procedures for communicating with emergency room personnel.
R.0183	Submit all documents outlined for the Network Certification demonstrating that the proposed Network meets the appropriate Network adequacy standards set forth in this Contract and Welfare and Institutions Code (W&I) section 14197. See APL 23-001 for document specification and submission guidelines. Network certification must be submitted in accordance with the requirements placed upon DHCS pursuant to 42 CFR section 438.66(e).
R.0184	Submit policies and procedures for providing Emergency Services including 24 hours a day access without Prior Authorization, follow-up and coordination of emergency care services.
R.0185	Submit policies and procedures for authorizing and arranging for out-of-Network access, including arranging transportation services for Members to access the out-of-Network Providers.

Identifier	Operational Readiness Requirement
R.0186	Submit policies and procedures for the provision of and access to each of the following: 1) Family planning services; 2) STD services; 3) HIV testing and counseling services; 4) Pregnancy termination; 5) Minor Consent Services; 6) Immunizations; 7) IHCP services; 8) CNM and NP services; 9) NSMHS for minors; and 10) Medication for Addiction Treatment (MAT).
R.0187	Submit policies and procedures for the timely referral and coordination of Covered Services to which Contractor, Subcontractor, or Downstream Subcontractor has moral objections to perform or otherwise support.
R.0188	Submit policies and procedures for the provision of 24 hour interpreter services at key points of contact.
R.0189	Submit policies and procedures regarding Contractor, Subcontractor, and Downstream Subcontractor compliance with State and federal language and communication assistance requirements.
R.0190	Submit policies and procedures regarding Contractor, Subcontractor, and Downstream Subcontractor compliance with civil rights laws requiring access for Members with disabilities.
R.0191	Submit a written description of the C&L services program and policies and procedures for monitoring and evaluation of the C&L services program.
R.0192	Submit an analysis demonstrating the ability of Contractor's Network to meet the ethnic, cultural, and linguistic needs of Contractor's Members.
R.0193	Submit policies and procedures for providing cultural competency/humility, sensitivity or diversity training for staff, Network Providers, Subcontractors, and Downstream Subcontractors at key points of contact.
R.0194	Submit policies and procedures describing Contractor's Member and family engagement strategy and how Contractor will ensure Member and/or parent and caregiver input into appropriate policies and decision-making.
R.0195	Submit policies and procedures describing how Contractor will ensure the following with regards to the Community Advisory Committee (CAC): 1) How Contractor will ensure a diverse membership on the CAC that is reflective of Contractor's Service Area and includes adolescents and/or parents/caregivers of Members less than 21 years of age; 2) How Contractor will support Member participation in the CAC; 3) How Contractor will ensure the CAC will be involved in appropriate policies and decision-making; and 4) How Contractor will actively facilitate communication and connection between the CAC and Contractor leadership.

Identifier	Operational Readiness Requirement
R.0196	Submit policies and procedures for providing continuity of care including the completion of Covered Services by Providers and out-of-Network Providers.
R.0197	Submit policies and procedures for performance of Facility Site Reviews (FSR) and Medical Record reviews (FSR Attachments A and B), and performance of Facility Site physical accessibility reviews (FSR Attachment C).
R.0198	Submit the aggregate results of pre-operational Site Reviews to DHCS at the request of DHCS. The aggregate results must include all data elements specified by DHCS.

EXHIBIT A, ATTACHMENT III – 5.3 SCOPE OF SERVICES

Identifier	Operational Readiness Requirement
R.0199	Submit policies and procedures, including standards, for the provision of each of the following services for Members less than 21 years of age: 1) Children's preventive services; 2) Immunizations; 3) Blood Lead screens; and 4) EPSDT services.
R.0200	Submit policies and procedures for the provision of adult preventive services, including immunizations.
R.0201	Submit policies and procedures for the provision of each of the following services to pregnant Members: 1) Prenatal and postpartum care; 2) Use of American College of Obstetricians and Gynecologists (ACOG) standards and guidelines; 3) Comprehensive risk assessment tool for all pregnant Members; and 4) Referral to Specialists.
R.0202	Submit a list of appropriate hospitals available within the Network that provide necessary high-risk pregnancy services.
R.0203	Provide a detailed description of health education system including policies and procedures regarding delivery of services, administration, and oversight.
R.0204	Provide a list and schedule of all health education classes and/or programs.
R.0205	Submit policies and procedures for the provision of Emergency Medical Transportation (EMT), Non-Emergency Medical Transportation (NEMT), and Non-Medical Transportation (NMT).
R.0206	Submit policies and procedures that define and describe what mental health services are to be provided by a licensed mental health care Provider.
R.0208	Submit policies and procedures for the provision of Major Organ Transplants as Covered Services.
R.0209	Submit policies and procedures for the provision of Long-Term Care (LTC) as Covered Services.

Identifier	Operational Readiness Requirement
R.0210	Submit policies and procedures for the provision of services at non-contracted LTC facilities.
R.0211	Submit policies and procedures for conducting a Drug Use Review (DUR).
R.0212	Submit policies and procedures for the UM of covered pharmaceutical services, demonstrating compliance with mental health parity requirements set forth in 42 CFR section 438.900 *et seq*.
R.0213	Submit policies and procedures for the coverage of clinical trials and routine patient care costs.

EXHIBIT A, ATTACHMENT III – 5.4 COMMUNITY BASED ADULT SERVICES

Identifier	Operational Readiness Requirement
R.0215	Submit policies and procedures for referring a Member to a Community Based Adult Services (CBAS) Provider.
R.0216	Submit policies and procedures on arranging for the provision of CBAS unbundled services.
R.0217	Submit all policies and procedures required by the California Advancing and Innovating Medi-Cal (CalAIM) Terms and Conditions, Section V.A.23.
R.0218	Submit policies and procedures for the initial assessment and reassessment of Members for eligibility to receive CBAS, including circumstances where Contractor may forgo a face-to-face review if eligibility has already been determined through another process.
R.0219	Submit policies and procedures for an expedited assessment process.
R.0220	Submit final draft of the written notice to be sent to Members after a CBAS assessment determination that results in a change to the Member's CBAS benefit.
R.0253	Submit all policies and procedures on providing CBAS Emergency Remote Services (ERS).
R.0254	Submit policies and procedures for community participation for Members receiving CBAS.
R.0255	Submit policies and procedures for notifying DHCS of payments made to a CBAS Provider involved in a credible allegation of Fraud.

EXHIBIT A, ATTACHMENT III – 5.5 MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS

Identifier	Operational Readiness Requirement
R.0207	Submit policies and procedures for when a Member becomes eligible for SMHS and/or SUD treatment services during the course of receiving NSMHS, including how Contractor will use required State-approved transition of care tool for coordinating care between Contractor and MHPs.
R.0213	Submit policies and procedures for handling of psychiatric emergencies during non-business hours.

Identifier	Operational Readiness Requirement
R.0214	Submit policies and procedures for verifying the credentials of licensed mental health Providers of NSMHS.
R.0222	Submit policies and procedures for entering into agreements with MHPs, Non-Specialty Mental Health Services Providers, county DMC-ODS plans, counties administering California Medicaid State Plan benefits, and SUD treatment Providers in order to comply with access standards and Care Coordination requirements, including those concerning the concurrent provision of covered NSMHS and SMHS consistent with WI section 14184.402(f)(1).
R.0223	Submit policies and procedures for the provision of SUD services including drug and alcohol Screening, Assessment, Brief Intervention and Referral to Treatment (SABIRT) services, including: 1) Provision of SABIRT by a Member's PCP to identify, reduce, and prevent problematic substance use; 2) Referral, without requiring Prior Authorization, for SABIRT services for Members whose PCPs do not offer SABIRT services; and 3) Referral of Members to SUD treatment without requiring Prior Authorization, when there is a need beyond SABIRT services.

EXHIBIT A, ATTACHMENT III – 5.6 MOUs WITH LOCAL GOVERNMENT AGENCIES, COUNTY PROGRAMS, AND THIRD PARTIES

Identifier	Operational Readiness Requirement
R.0224	Submit executed MOUs, or documentation substantiating Contractor's efforts to negotiate MOUs to coordinate programs and services for Members with LGAs, third-party entities and county programs in Contractor's Service Area, even if Contractor is coordinating care and not financially responsible, to ensure Care Coordination, data sharing, and non-duplicative services for Members, including, but not limited to: 1) LHDs in each County within Contractor's Services Area for the following programs and services: a) CCS; b) Maternal and Child Health (MCH); c) TB Direct Observed Therapy (DOT); and d) Community Health Workers (CHW). 2) WIC agencies in each county within Contractors' Service Area. 3) LGAs such as the County Behavioral Health Department and County Social Services Department, in each county within Contractors' Service Area to assist with coordinating the following programs and services: a) SMHS; b) Alcohol and SUD treatment services, including counties administering State plan Drug Medi-Cal benefits and counties participating in DMC-ODS; and c)IHSS. 4) LGAs to coordinate programs and services for Members in each county within Contractors Service Area at a minimum: a) Social Services; and b) Child welfare departments. 5) RCs for persons with DDs.
R.0225	Submit executed MOUs, or documentation substantiating Contractor's efforts to negotiate MOUs to coordinate programs and services for Members with LGAs, third-party entities, and county programs in Contractor's Service Area, even if Contractor is coordinating care and not financially responsible, to ensure Care Coordination, data sharing, and non-duplicative services for Members, including at a minimum: 1) Third-party entities in each county within Contractor's Service Area, at a minimum, First 5 County Commissions.
R.0226	Submit policies and procedures for exchanging Member Information with MHPs and DMC-ODS or county Drug Medi-Cal Programs in compliance with State and federal privacy laws and regulations.
R.0227	Submit policies and procedures for maintaining collaboration among the parties to the MOU and monitoring and assessing the effectiveness of MOUs. Policies and procedures should include the requirement to review its MOUs annually for any needed modifications or renewal of responsibilities and obligations.

Identifier	Operational Readiness Requirement
R.0228	Submit executed MOUs, or documentation substantiating Contractor's efforts to negotiate MOUs to coordinate programs and services for Members with LGAs in each county within Contractor's Service Area to assist with coordinating, at a minimum, Targeted Case Management (TCM).
R.0256	Submit executed MOUs, or documentation substantiating Contractor's efforts to negotiate MOUs to coordinate programs and services for Members with LGAs, third-party entities, and county programs in Contractor's Service Area, even if Contractor is coordinating care and not financially responsible, to ensure Care Coordination, data sharing, and non-duplicative services for Members, including at a minimum: 1) LEAs for IEPs or IFSPs; 2) California Department of Corrections and Rehabilitation, County Jails, and Youth Correctional Facilities, as applicable.

EXHIBIT A, ATTACHMENT III – 6.0 EMERGENCY PREPAREDNESS AND RESPONSE

Identifier	Operational Readiness Requirement
R.0239	Submit Emergency Preparedness and Response Plan.
R.0229	Submit Risk Assessment and Emergency Plan.
R.0230	Submit Policies and Procedures to support execution of emergency plan and risks identified.
R.0231	Submit Communication Plan to Providers/facilities/contracted entities.
R.0232	Submit training and testing program for emergency preparedness.

EXHIBIT B, BUDGET DETAIL AND PAYMENT PROVISIONS

Identifier	Operational Readiness Requirement
R.0233	Submit documentation of the Coordination of Benefits Agreement (COBA) that Contractor has entered into with Medicare.

EXHIBIT C, GENERAL TERMS AND CONDITIONS

No deliverables listed for this Exhibit.

EXHIBIT D(f), SPECIAL TERMS AND CONDITIONS

No deliverables listed for this Exhibit.

EXHIBIT E, PROGRAM TERMS AND CONDITIONS

Identifier	Operational Readiness Requirement
R.0234	Submit policies and procedures explaining Contractor's data certification reporting method. Policies and procedures must include a template certification statement.
R.0235	Submit policies and procedures for the treatment of recoveries, including retention policies, process, timeframes, and documentation for reporting, for all recovery of overpayments.
R.0236	Submit policies and procedures for how Contractor will comply with Cost Avoidance and Post-Payment Recovery for Members with Other Healthcare Coverage (OHC).
R.0237	Submit policies and procedures for how Contractor will comply with Third-Party Tort and Worker's Compensation Liability.
R.0238	Submit policies and procedures for how Contractor will comply with an investigation or a prosecution conducted by the Division of Medi-Cal Fraud and Elder Abuse (DMFEA) and/or the United States Department of Justice (US DOJ), including communicating requirements with Subcontractors and Downstream Subcontractors.

EXHIBIT F, CONTRACTOR'S RELEASE

No deliverables listed for this Exhibit.

EXHIBIT G, BUSINESS ASSOCIATE ADDENDUM

No deliverables listed for this Exhibit.

EXHIBIT H, CONFLICT OF INTEREST AVOIDANCE REQUIREMENTS

Identifier	Operational Readiness Requirement
R.0241	Submit updated report on any conflicts of interest and/or conflict avoidance plan, if requested by DHCS.

EXHIBIT I, CONTRACTOR'S PARENT GUARANTY REQUIREMENTS

Identifier	Operational Readiness Requirement
R.0242	Submit parent guaranty, if applicable.

EXHIBIT J, DELEGATION REPORTING AND COMPLIANCE PLAN

Identifier	Operational Readiness Requirement
R.0243	Submit delegation reporting and compliance plan (Template A, B, and C).

EXHIBIT K, EXCLUDED PROVISIONS AS TO CONTRACTORS NOT LICENSED PURSUANT TO THE KNOX-KEENE HEALTH CARE SERVICE PLAN ACT OF 1975

No deliverables listed for this Exhibit.

EXHIBIT L, REQUIREMENTS SPECIFIC TO CONTRACTOR

Any deliverables for Contractor-specific requirements will be stated in Exhibit L.

Exhibit A, ATTACHMENT III

1.0 Organization

The Department of Health Care Services (DHCS) seeks to ensure that only those managed care plans that have the organizational capacity, leadership, financial well-being, commitment to invest in our communities, and demonstrated ability to ensure program integrity and compliance with all applicable federal and State requirements and standards under this Contract, may be Contractors.

Article 1.0 outlines DHCS' requirements for plan organization and administration including key leadership roles, including the designation of a Chief Health Equity Officer having the authority to design and implement policies that ensure Health Equity is prioritized and addressed. Key personnel changes, including those relevant to Contractor, Subcontractors, and Downstream Subcontractors, must be reported to DHCS in a timely fashion. The financial health and well-being of Contractors are vital to ensuring access to Medi-Cal Covered Services, and, as such DHCS, requires reporting of financial data for review. In addition, DHCS will ensure minimum loss ratios are in place for Contractors, Subcontractors, and Downstream Subcontractors who take financial risk to provide services for Members. Additionally, requiring that a portion of profits invested back into the community, will help ensure that Contractors are seeking opportunities to work at a local level to further efforts to address Social Drivers of Health (SDOH) and drive improvements in quality, equity, and access to care.

Article 1.0 also outlines requirements for Contractors to ensure that they have a clear compliance plan to meet the requisite personnel, processes, and capacity as outlined in the Contract.

1.1 Plan Organization and Administration

1.1.1 Legal Capacity
1.1.2 Key Personnel Disclosure Form
1.1.3 Conflict of Interest – Current and Former State Employees
1.1.4 Contract Performance
1.1.5 Medical Decisions
1.1.6 Medical Director
1.1.7 Chief Health Equity Officer
1.1.8 Key Personnel Changes
1.1.9 Administrative Duties/Responsibilities
1.1.10 Member Representation
1.1.11 Diversity, Equity, and Inclusion Training

Exhibit A, ATTACHMENT III

1.1 Plan Organization and Administration

1.1.1 Legal Capacity

Contractor must maintain the legal capacity to contract with Department of Health Care Services (DHCS) and, if required, maintain appropriate licensure as a health care service plan in accordance with the Knox-Keene Health Care Service Plan Act of 1975 (KKA) as amended (Health and Safety Code (H&S) section 1340 *et seq.*). If Contractor is not currently licensed to operate in an awarded Service Area, within 30 Working Days of award of Contract, it must submit a material modification to its license to the Department of Managed Health Care (DMHC) requesting authorization to operate in the Service Area. Contractor must submit proof of its material modification submission to DHCS concurrently. Operations Period will not begin until the material modification is approved by DMHC. Within three Working Days of approval, Contractor must submit a copy of its approved and amended Knox-Keene license to DHCS.

1.1.2 Key Personnel Disclosure Form

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

   1) Any person or corporation having five percent or more ownership or controlling interest in Contractor;

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

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

B. Contractor must comply with 42 Code of Federal Regulations (CFR) sections 455.104 (Disclosure by Medicaid providers and fiscal agents: Information on ownership and control), 455.105 (Disclosure by providers: Information related to business transactions), 455.106 (Disclosure by providers: Information on persons convicted of crimes), and 438.610 (Prohibited affiliations).

1.1.3 Conflict of Interest – Current and Former State Employees

A. This Contract will be governed by the conflict of interest provisions of 42 CFR sections 438.3(f)(2) and 438.58 and 22 California Code of Regulations (CCR) sections 53874 and 53600.

B. In the performance of this Contract, Contractor will not utilize any State officer, employee in State civil service, other appointed State official, or intermittent State employee, or contracting consultant for DHCS, unless the employment, activity, or enterprise is required as a condition of the officer's or employee's regular State employment.

1.1.4 Contract Performance

Contractor must maintain the necessary organization and level of staffing to implement and operate this Contract in accordance with 28 CCR section 1300.67.3 and 22 CCR sections 53800, 53851, and 53857. Contractor must ensure the following:

A. Contractor has an accountable Governing Board;

B. Compliance with this Contract is a high priority and that Contractor is committed to supplying any necessary resources to assure full performance of the Contract;

C. If Contractor is a subsidiary organization, its parent organization provides an attestation confirming that this Contract will be a high priority to the parent organization and committing to supply any necessary resources to assure full performance of the Contract;

D. Adequate staffing in medical and other health services, fiscal and administrative capacity sufficient to effectively conduct Contractor’s business; and

E. Written procedures are developed and maintained for conducting Contractor’s business, including the provision of health care services, in compliance with federal and State Medicaid law.

1.1.5 Medical Decisions

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

1.1.6 Medical Director

Contractor must appoint a physician as medical director pursuant to 22 CCR section 53857 whose responsibilities must include, but should not be limited to, the following:

A. Ensuring that medical and other health services decisions are:

   1) Rendered by qualified medical personnel; and

   2) Not influenced by fiscal or administrative management considerations.

B. Ensuring that the medical and other health care provided meets acceptable standards of care;

C. Ensuring that Contractor's medical personnel follow medical protocols and rules of conduct;

D. Developing and implementing medical policy consistent with applicable standards of care;

E. Resolving Grievances related to Quality of Care;

F. Participating directly in the implementation of Quality Improvement and Health Equity activities;

G. Participating directly in the design and implementation of the Population Health Management Strategy and initiatives, including Population Needs Assessment design, planning, and implementation to inform Strategy;

H. Participating actively in the execution of Grievance and Appeal procedures;

I. Ensuring that Contractor engages with local health departments; and

J. Posting medical director contact information in an easily accessible location on their provider portal website.

1.1.7 Chief Health Equity Officer

Contractor must maintain a full-time Chief Health Equity Officer who has the necessary qualifications or training at the time of hire or within one year of hire to meet the requirements of the position. The Chief Health Equity Officer responsibilities must include, but should not be limited to, the following:

A. Provide leadership in the design and implementation of Contractor's strategies and programs to ensure Health Equity is prioritized and addressed;

B. Ensure all Contractor policy and procedures consider Health Inequities and are designed to promote Health Equity where possible, including but not limited to:

1) Marketing strategy;

2) Medical and other health services policies;

3) Member and provider outreach;

4) Community Advisory Committee;

5) Quality Improvement activities, including delivery system reforms;

6) Grievance and Appeals; and

7) Utilization Management.

C. Develop and implement policies and procedures aimed at improving Health Equity and reducing Health Disparities;

D. Engage and collaborate with Contractor staff, Subcontractors, Downstream Subcontractors, Network Providers, and entities including, but not limited to local community-based organizations, local health departments, Behavioral Health and social services, Child welfare systems and Members in Health Equity efforts and initiatives;

E. Participate in community reinvestment activities as set forth in this Contract (Ex. B, Subsection 1.1.17 (*Community Reinvestment*) and APL 25-004;

F. Implement strategies designed to identify and address root causes of Health Inequities, which includes but is not limited to systemic racism, Social Drivers of Health, and infrastructure barriers;

G. Develop targeted interventions designed to eliminate Health Inequities;

H. Develop quantifiable metrics that can track and evaluate the results of the targeted interventions designed to eliminate Health Inequities;

I. Ensure all Contractor, Subcontractor, Downstream Subcontractor, and Network Provider staff receive mandatory diversity, equity and inclusion

training (sensitivity, diversity, communication skills, and cultural competency/humility training) biennially, as specified in Exhibit A, Attachment III, Subsection 5.2.11.C. (*Cultural and Linguistic Programs and Committees*). This includes, but is not limited to:

1) Reviewing training materials to ensure the materials are up to date with current standards of practice; and

2) Maintaining records of training completion.

1.1.8 Key Personnel Changes

Contractor must report to DHCS Contract Manager any changes in the status of the executive-level personnel including, but not limited to the chief executive officer, chief financial officer, chief operations officer, the chief medical director, the chief Health Equity officer, the compliance officer, and government relations persons no later than ten calendar days prior to the effective date of the change.

1.1.9 Administrative Duties/Responsibilities

Contractor must maintain the organizational and administrative capabilities to carry out Contractor's duties and responsibilities under the Contract. At a minimum, Contractors' responsibilities must include the following:

A. Comply with all requirements and deliverables as described in Exhibit A, Attachment II, Article 1.0 (*Operational Readiness Deliverables and Requirements*);

B. Maintain financial records and books of account on an accrual basis, in accordance with Generally Accepted Accounting Principles (GAAP), which fully disclose the disposition of all Medi-Cal program funds received, as specified in Exhibit A, Attachment III, Section 1.2 (*Financial Information*);

C. Maintain a Member and Enrollment reporting systems as specified in Exhibit A, Attachment III, Section 2.1 (*Management Information System*), Section 4.6 (*Member Grievance and Appeal System*), and Section 5.1 (*Member Services*);

D. Maintain data reporting capabilities sufficient to provide necessary and timely reports to DHCS, as required by Exhibit A, Attachment III, Section 2.1 (*Management Information System*);

E. Maintain data and information exchange capabilities as needed to meet Contractor's obligation under the Contract and to support DHCS administration of the Medi-Cal program through data sharing with other trading partners. This includes, but is not limited to, Encounter Data,

Medical Record information, Network Provider and Provider information, Member demographics, and case notes;

F. Maintain Quality Improvement activities and Population Health Management activities. Comply with all National Committee for Quality Assurance (NCQA) and accreditation requirements by calendar year 2026 as described in Exhibit A, Attachment III, Section 2.2 (*Quality Improvement and Health Equity Transformation Program (QIHETP)*);

G. Maintain a Utilization Management (UM) program, as described in Exhibit A, Attachment III, Section 2.3 (*Utilization Management Program*);

H. Maintain Network adequacy as described in Exhibit A, Attachment III, Section 5.2 (*Network and Access to Care*);

I. Comply with requirements, as described in Exhibit A, Attachment III, Section 3.2 (*Provider Relations*);

J. Maintain claims processing capabilities as described in Exhibit A, Attachment III, Section 3.3 (*Provider Compensation Arrangements*);

K. Maintain adequate access and availability of Primary Care Providers (PCP) and Specialists for all Medically Necessary Covered Services for Members, as described in Exhibit A, Attachment III, Section 5.2 (*Network and Access to Care*);

L. Form a Community Advisory Committee (CAC) and meet expectations, as described in Exhibit A, Attachment III, Section 5.2 (*Network and Access to Care*), including CAC's active participation in addressing Quality of Care, Health Equity, Health Disparities, Population Health Management, Children services, and other ongoing Contractor functions;

M. Provide or arrange for all Medically Necessary Covered Services for Members, as described in Exhibit A, Attachment III, Section 5.3 (*Scope of Services*), Exhibit A, Attachment III, Section 5.4 (*Community Based Adult Services*), and Exhibit A, Attachment III, Section 5.5 (*Mental Health and Substance Use Disorder Benefits*);

N. Provide Care Coordination, including but not limited to all Medically Necessary services delivered both within and outside Contractor's Network, as described in Exhibit A, Attachment III, Section 4.3 (*Population Health Management and Coordination of Care*);

O. Negotiate in good faith and execute Network Provider Agreements, Subcontractor Agreements, or Memorandums of Understanding (MOUs), as appropriate, with third party entities, including county programs, and

local health jurisdictions covered by this Contract, as described in Exhibit A, Attachment III, Section 5.6 (*MOUs with Local Government Agencies, County Programs, and Third Parties*) and Exhibit A, Attachment III, Subsection 3.1.9 *(Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements with Local Health Departments)*;

P. Comply with the requirements described in Exhibit A, Attachment III, Section 5.1 (*Member Services*);

Q. Maintain Member Grievance procedures, as specified in Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*);

R. Develop training and certification for Marketing activity, if Contractor conducts Marketing, as described in Exhibit A, Attachment III, Section 4.1 (*Marketing*);

S. Cooperate with the DHCS Enrollment program, as described in Exhibit A, Attachment III, Section 4.2 (*Enrollments and Disenrollments*); and

T. Comply with all requirements and deliverables, as described in Exhibit A, Attachment III, Article 7.0 (*Operations Deliverables and Requirements*).

1.1.10 Member Representation

Contractor must ensure that Medi-Cal Members, including Seniors and Persons with Disabilities (SPD), persons with chronic conditions (such as asthma, diabetes, congestive heart failure), Limited English Proficient (LEP) Members, and Members from diverse cultural and ethnic backgrounds or their representatives are included and invited to participate in establishing public policy within Contractor's advisory committee and CAC, as specified in Exhibit A, Attachment III, Subsection 5.2.11.E. (*Cultural and Linguistic Programs and Committees*), or other similar committees or groups.

1.1.11 Diversity, Equity, and Inclusion Training

Contractor must ensure that all staff who interact with, or may potentially interact with, Members and any other staff deemed appropriate by Contractor or DHCS, receive biennial sensitivity, diversity, communication skills, and cultural competency/humility training as specified in Exhibit A, Attachment III, Subsection 5.2.11.C. (*Cultural and Linguistic Programs and Committees*).

Exhibit A, ATTACHMENT III

1.2 Financial Information

1.2.1 Financial Viability and Standards Compliance
1.2.2 Contractor's Financial Reporting Obligations
1.2.3 Independent Financial Audit Reports
1.2.4 Cooperation with DHCS' Financial Audits
1.2.5 Medical Loss Ratio
1.2.6 Contractor's Obligations
1.2.7 Community Reinvestment Plan and Report

1.2 Financial Information

1.2.1 Financial Viability and Standards Compliance

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

A. Tangible Net Equity (TNE).

Contractor at all times must be in compliance with the TNE requirements set forth in 28 California Code of Regulations (CCR) section 1300.76, even in circumstances where Contractor is not otherwise legally required to comply with this provision.

B. Administrative Costs.

Contractor's Administrative Costs must comply with the standards set forth in 22 CCR section 53864(b) and 28 CCR section 1300.78.

C. Standards of organization and financial soundness.

Contractor must maintain an organizational structure sufficient to conduct the operations required by this Contract and ensure that its financial resources are sufficient for sound business operations in accordance with 28 CCR sections 1300.67, 1300.67.3, 1300.75.1, 1300.75.4.1, 1300.76.3, 1300.77.1, 1300.77.2, 1300.77.3, and 1300.77.4.

D. Working Capital Ratio of one of the following:

1) Contractor must maintain a Working Capital Ratio of current assets to current liabilities of at least 1:1 in accordance with Health & Safety Code (H&S) section 1375.4(b)(1)(A)(iv); or

2) Contractor must demonstrate to DHCS that Contractor is meeting financial obligations on a timely basis and has been doing so for at least the preceding two years; or

3) Contractor must provide evidence that sufficient noncurrent assets, which are readily convertible to cash, are available to achieve an equivalent Working Capital Ratio of 1:1, if the noncurrent assets are considered current.

E. In the event DHCS finds Contractor non-compliant with any of the elements or obligations set forth in this provision, DHCS may impose a Corrective Action plan or sanctions in accordance with Exhibit E (*Program Terms and Conditions*) and Welfare and Institutions Code (W&I) section

14197.7, as set forth in All Plan Letter (APL) 25-007. See Exhibit E, Section 1.19 (*Sanctions*).

1.2.2 Contractor's Financial Reporting Obligations

A. Form and Standards for Financial Reporting

Contractor must provide financial information and reports, including but not limited to Financial Statements, to DHCS in the form and manner specified by DHCS. Unless otherwise specified by DHCS, Contractor must prepare all financial information requested by DHCS in accordance with Generally Accepted Accounting Principles (GAAP) and the 1989 Health Maintenance Organization (HMO) Financial Report of Affairs and Conditions format. Any Department of Managed Health Care (DMHC) required reports must be prepared in DMHC-required financial reporting format, and in accordance with 28 CCR section 1300.84. Information submitted by Contractor must be based on current operations. Where appropriate, reference has been made to the Knox-Keene Health Care Service Plan Act of 1975 (KKA) rules found under 28 CCR sections 1300.51 *et seq*.

Unless otherwise specified by DHCS, all Financial Statements must include, at a minimum, the following reports/schedules unless explicitly excluded in this Attachment:

1) Jurat;

2) Report 1A and 1B: Balance Sheet;

3) Report 2: Statement of Contract Revenue, Expenses, and Net Worth;

4) Statement of Cash Flow, prepared in accordance with Financial Accounting Standards Board Statement Number 95 in lieu of Report 3: Statement of Changes in Financial Position for GAAP compliance;

5) Report 4: Enrollment and Utilization Table;

6) Schedule G: Unpaid Claims Analysis;

7) Appropriate footnote disclosures in accordance with GAAP; and

8) Schedule H: Aging of All Claims.

In addition, Contractor must prepare and submit a stand-alone Medi-Cal line of business income statement and Enrollment table on each financial reporting period required. Contractor must prepare this income statement and Enrollment table in the DMHC required financial reporting format for each specific county or rating region of operation, as specified by DHCS and must include, at a minimum, the following reports/schedules:

1) Report 2: Statement of Contract Revenue and Expenses; and

2) Report 4: Enrollment and Utilization Table by County/Rating Region.

Medi-Cal line of business Financial Statements are to include expenses, Contract Revenues, and Enrollment only for Medi-Cal Members enrolled through direct contract with DHCS.

Contactor must submit the Medi-Cal line of business Financial Statements within the same timeframe as indicated for each required Financial Statement.

B. Monthly Reporting Obligations

Contractor must submit to DHCS, no later than 30 calendar days after the close of Contractor's fiscal month, an exact copy of any reports required be filed in accordance with 28 CCR section 1300.84.3.

C. Quarterly Reporting Obligations

Contractor must submit to DHCS, no later than 45 calendar days after the close of Contractor's fiscal quarter, an exact copy of any reports required to be filed in accordance with 28 CCR section 1300.84.2.

D. Annual Reporting Obligations

Contractor must prepare and submit to DHCS, no later than 120 calendar days after the close of Contractor's Fiscal Year, an exact copy of any reports required to be filed in accordance with 28 CCR section 1300.84.06. Contractor must also submit Medi-Cal line of business Financial Statements no later than 120 calendar days of after the close of the applicable Rating Period.

E. Annual Forecasts

Contractor must submit to DHCS annual forecasts of Contractor's next Fiscal Year no later than 60 calendar days prior to the beginning each Fiscal Year. Contractor's annual forecast must be prepared using DMHC

required financial reporting forms and must include, at a minimum, the following reports/schedules:

1) Report 2: Statement of Contract Revenue and Expenses (Medi-Cal line-of-business);

2) Report 4: Enrollment and Utilization Table by County/Rating Region (Medi-Cal line-of-business);

3) TNE (All lines of business); and

4) A detailed explanation of all underlying assumptions used to develop the forecast.

F. Publication of Financial Reports

Financial Reports submitted in accordance with this Section 1.2 are public records and may be made public by DHCS.

1.2.3 Independent Financial Audit Reports

Contractor must ensure that an annual audit is performed by an independent Certified Public Accountant in accordance with 42 Code of Federal Regulations (CFR) section 438.3(m) and W&I section 14459. Except as indicated in Paragraph B of this provision, a copy of the resulting independent financial audit report must be submitted to DHCS no later than 120 calendar days after the close of Contractor's Fiscal Year.

When the delivery of care or other services is dependent upon Affiliates of Contractor, Contractor must submit combined, annual Financial Statements that reflect the financial position of Contractor's overall health care delivery system in accordance with 28 CCR section 1300.84(c). Such combined, annual Financial Statements must be presented in a form that clearly shows the financial position of Contractor separately from the combined totals set forth in the combined Financial Statements. Intra-entity or related party transactions and profits must be eliminated if consolidated Financial Statements are prepared and submitted by Contractor. Contractor also must submit to DHCS any financial audit conducted by DMHC pursuant to H&S section 1382 within 30 calendar days of Contractor's receipt thereof.

In the event that Contractor's retained independent Certified Public Accountant determines that preparation of combined, annual Financial Statements is inappropriate or impracticable under the circumstances, separate certified Financial Statements must be prepared for each entity involved in the delivery of health care services by Contractor, and such separate, annual Financial Statements must be submitted to DHCS, along with the following:

A. Contractor must provide the independent Certified Public Accountant's written statement of the reasons for not preparing combined Financial Statements;

B. Contractor must provide supplemental schedules that clearly reflect all intra-entity or related party transactions and eliminations necessary to enable DHCS to analyze the overall financial position of Contractor's entire health care delivery system. If Contractor is a public entity or a political subdivision of the State and a county grand jury conducts Contractor's financial audits, Contractor must submit its Financial Statements within 180 calendar days after the close of Contractor's Fiscal Year in accordance with H&S section 1384;

C. Contractor must authorize its independent Certified Public Accountant to allow DHCS' designated representatives or agents, upon written request, to inspect any and all working papers related to the preparation of the audit report;

D. Contractor must submit to DHCS all financial reports relevant to Affiliates as specified in 28 CCR section 1300.84(c); and

E. Contractor must submit to DHCS copies of any financial reports submitted to any other public or private organization within ten calendar days of submission to such other public or private organization.

1.2.4 Cooperation with DHCS' Financial Audits

DHCS must conduct, or contract for the conduct of, periodic audits of the accuracy, truthfulness, and completeness of the financial data submitted by, or on behalf of, Contractor in accordance with 42 CFR section 438.602(e). Contractor must cooperate with these audits and provide all information and materials requested by DHCS, or its contracted auditor, for this purpose. Please see Exhibit A, Attachment III, Section 2.1 (*Management Information System*) for related requirements.

1.2.5 Medical Loss Ratio

Contractor must annually report a Medical Loss Ratio (MLR) as described in this provision and in accordance with 42 CFR section 438.8. Contractor must impose equivalent MLR reporting requirements on Fully Delegated Subcontractors, Partially Delegated Subcontractors, Downstream Fully Delegated Subcontractors, and Downstream Partially Delegated Subcontractors.

A. Contractor must calculate and report a MLR as stated in 42 CFR sections 438.8 and 438.604(a)(3) in a form and manner specified by DHCS.

1) Contractor must ensure that revenues, expenditures, and other amounts are appropriately identified and classified including by distinguishing which amounts were actually paid for benefits or activities that improve health care quality, and which amounts were actually paid for administrative services, taxes, or other activities in accordance with the Centers for Medicare & Medicaid Services (CMS) Informational Bulletin published May 15, 2019, with the subject “Medical Loss Ratio Requirements Related to Third-Party Vendors.”

2) Contractor must, in compliance with 42 CFR section 438.230(c)(1) and California Advancing and Innovating Medi-Cal (CalAIM) Terms and Conditions, in particular Paragraph 11 of the 1915(b) Waiver STCs, require all applicable Subcontractors and Downstream Subcontractors to comply with the MLR reporting responsibilities in this Section, including the requirement to distinguish which amounts are actually paid for benefits or activities that improve health care quality, and which amounts were actually paid for administrative services, taxes, or other activities in accordance with the CMS Informational Bulletin published May 15, 2019 with the subject “Medical Loss Ratio Requirements Related to Third-Party Vendors.” Payments to a Subcontractor or Downstream Subcontractor that are not the amount actually paid to a Provider or supplier for furnishing Covered Services must not be included in incurred claims.

B. The MLR experienced by Contractor in a MLR reporting year is the ratio of the numerator, as stated in Paragraph E of this Section, to the denominator, as stated in Paragraph F of this Section. A MLR may be increased by a credibility adjustment in accordance with Paragraph H of this provision.

C. DHCS utilizes a materiality threshold for determining whether Fully Delegated Subcontractors, Partially Delegated Subcontractors, Downstream Fully Delegated Subcontractors, and Downstream Partially Delegated Subcontractors are subject to the reporting and remittance requirements. The materiality threshold may be based on one or more of the following:

1) Annual Medi-Cal revenue;

2) The Medi-Cal lives for which risk is delegated;

3) The scope of Medi-Cal services for which risk is delegated; or

4) Other factors.

D. Subcontractors and Downstream Subcontractors that fall below the materiality threshold for an MLR reporting year, as specified by DHCS, are not subject to MLR reporting for that MLR reporting year. DHCS reserves the right to reestablish the threshold annually, may require reporting by certain Subcontractors and Downstream Subcontractors regardless of materiality, and will communicate details of the materiality threshold and subsequent updates and/or changes through APLs or other instruction.

E. The numerator of Contractor's, Subcontractors', and Downstream Subcontractors' MLR for a MLR reporting year is the sum of Contractor's, Subcontractors', and Downstream Subcontractors' unduplicated incurred claims, expenditures for activities that improve health care quality, and Fraud prevention activities.

1) Contractor's, Subcontractors', and Downstream Subcontractors' Incurred Claims

a) Incurred claims must include the following:

i. Direct claims that Contractor, Subcontractors, and Downstream Subcontractors, as applicable, paid to Providers, including under capitated contracts with Network Providers, for Covered Services or supplies under this Contract, a Subcontractor Agreement, or a Downstream Subcontractor Agreement, as applicable, and meeting the requirements of 42 CFR section 438.3(e);

ii. Unpaid claims liabilities for the MLR reporting year, including claims reported that are in the process of being adjusted or claims Incurred but Not Reported;

iii. Withholds from payments made to Network Providers;

iv. Claims that are recoverable for anticipated coordination of benefits;

v. Claims payments recoveries received due to subrogation;

vi. Incurred but Not Reported claims based on past experience, and modified to reflect current conditions,

such as changes in exposure or claim frequency or severity;

vii. Changes in other claims-related reserves; and

viii. Reserves for contingent benefits and the medical claim portion of lawsuits.

b) Amounts that must be deducted from incurred claims include the following:

i. Identified unrecovered Overpayments and Overpayment recoveries received from Network Providers; and

ii. Prescription Drug rebates received and accrued.

c) Expenditures that must be included in incurred claims include the following:

i. The amount of incentive and bonus payments made, or expected to be made, to Network Providers that are tied to clearly-defined, objectively measurable, and well-documented clinical or quality improvement standards that apply to Providers; and

ii. The amount of claims payments recovered through Fraud reduction efforts, not to exceed the amount of Fraud reduction expenses. The amount of Fraud reduction expenses must not include activities specified in E.2.c of this provision.

iii. The amount of payments made to providers under Directed Payment Initiatives.

d) Amounts that must either be included in or deducted from incurred claims include, respectively, net payments or receipts related to solvency funds mandated by DHCS.

e) The following amounts must be excluded from incurred claims.

i. Non-claims costs, which include:

(1) the amounts paid to third-party vendors for secondary network savings;

(2) amounts paid to third-party vendors for network development, administrative fees, claims processing, and Utilization Management (UM);

(3) amounts paid for professional or administrative services, including amounts paid to a Provider, that do not represent compensation or reimbursement for California Medicaid State Plan services or services defined in 42 CFR section 438.3(e) and provided to Members; and

(4) amounts paid for fines and penalties assessed by regulatory authorities; and

ii. Amounts paid to DHCS as remittances in accordance with Paragraph P of this provision and Exhibit B of this Contract; and

iii. Amounts paid to upstream entities as remittance in accordance with Paragraph P of this Subsection. The contracts between all downstream entities in Contractor's delegation arrangement must include this reference; and

iv. Amounts paid to Network Providers under 42 CFR section 438.6(d).

f) Incurred claims paid by an entity that is later assumed by another entity must be reported by the assuming entity for the entire MLR reporting year and no incurred claims for that MLR reporting year may be reported by the ceding entity.

2) Activities that improve health care quality must be in one of the following categories:

a) Contractor's, Subcontractors', and Downstream Subcontractors', as applicable, activity that meets the requirements of 45 CFR section 158.150 (a) and (b) and is not excluded under 45 CFR section 158.150(c);

b) Contractor's**,** Subcontractors', and Downstream Subcontractors', as applicable, activity related to any External Quality Review-related activity as described in 42 CFR sections 438.358(b) and (c); or

c) Contractor's, Subcontractors', and Downstream Subcontractors', as applicable, expenditure that is related to Health Information Technology (HIT) and meaningful use, meets the requirements placed on issuers set forth in 45 CFR section 158.151, and is not considered incurred claims, as defined in this Subsection.

3) Contractor's, Subcontractors', and Downstream Subcontractors', as applicable, expenditures on activities related to Fraud prevention as described in 45 CFR part 158, and not including expenses for Fraud reduction efforts as stated in Paragraph E.1.c.ii of this Subsection.

F. The denominator of Contractor's, Subcontractors', and Downstream Subcontractors' MLR for a MLR reporting year must equal the adjusted premium revenue for Contractor's, Subcontractors', and Downstream Subcontractors' Medi-Cal line of business. The adjusted premium revenue is Contractor's, Subcontractors', and Downstream Subcontractors' premium revenue minus Contractor's, Subcontractors', and Downstream Subcontractors' federal, State, and local taxes and licensing and regulatory fees, and is aggregated in accordance with this Subsection.

1) Premium revenue includes the following for the MLR reporting year:

a) Capitation Payments, developed in accordance with 42 CFR section 438.4, and excluding payments made per 42 CFR section 438.6(d);

b) One-time payments for Member life events as specified in this Contract, including, but not limited to, Supplemental Payments and Additional Payments as set forth in provisions 1.7 and 1.8 of Exhibit B, respectively;

c) Other payments to Contractor approved under 42 CFR section 438.6(b)(3);

d) All changes to unearned premium reserves; and

e) Net payments or receipts related to Risk Sharing Mechanisms developed in accordance with 42 CFR sections 438.5 or 438.6.

f) Payments to Contractor for expenditures under Directed Payment Initiatives.

g) Notwithstanding (a)-(c), for Subcontractors and Downstream Subcontractors, premium revenue includes all payments received pursuant to a Subcontractor Agreement or Downstream Subcontractor Agreement, excluding payments received in accordance with 42 CFR section 438.6(d).

2) Taxes, licensing, and regulatory fees for the MLR reporting year must include:

a) Statutory assessments to defray the operating expenses of any State or federal department;

b) Examination fees in lieu of premium taxes as specified by State law;

c) Federal taxes and assessments allocated to Contractor, Subcontractors, or Downstream Subcontractors, as applicable, excluding federal income taxes on investment income, capital gains, and federal employment taxes;

d) State and local taxes and assessments including:

i. Any industry-wide or subset assessments, other than surcharges on specific claims, paid to the State or a locality directly.

ii. Guaranty fund assessments.

iii. Assessments of State or local industrial boards or other boards for operating expenses, or for benefits to sick employed persons in connection with disability benefit laws or similar taxes levied by the State.

iv. State or local income, excise, and business taxes, other than premium taxes and State employment and similar taxes and assessments.

v. State or local premium taxes, plus State or local taxes based on reserves, if in lieu of premium taxes.

e) Payments made by Contractor, Subcontractors, and Downstream Subcontractors, as applicable, that are otherwise exempt from federal income taxes, for community benefit expenditures as defined in 45 CFR section 158.162(c), limited to the higher of either:

i. 3 percent of earned premium; or

ii. The highest premium tax rate in the State, multiplied by Contractor's, Subcontractors', or Downstream Subcontractors', as applicable, earned premium in the State.

3) If Contractor, or any Subcontractor or Downstream Subcontractor, is later assumed by another entity that becomes the new Contractor, Subcontractor, or Downstream Subcontractor under this Contract, a Subcontractor Agreement, or a Downstream Subcontractor Agreement, the new Contractor, Subcontractor, or Downstream Subcontractors must report the total amount of the denominator for the entire MLR reporting year, and no amount under this Paragraph for that year may be reported by the ceding Contractor, Subcontractor, or Downstream Subcontractor.

G. In the allocation of expense, Contractor, Subcontractors, and Downstream Subcontractors must include each expense under only one type of expense, unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense must be pro-rated between types of expenses. Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be reported on a pro rata basis. Contractor, Subcontractors, and Downstream Subcontractors must use the following methods to allocate expenses:

1) Allocation to each category must be based on a Generally Accepted Accounting Principles (GAAP) method that is expected to yield the most accurate results;

2) Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the contract incurring the expense; and

3) Expenses that relate solely to the operation of a reporting entity, such as staff costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to the other entities.

H. Contractor, Subcontractors, and Downstream Subcontractors may add a credibility adjustment to a calculated MLR if the MLR reporting year experience is partially credible to account for a difference between the actual and target MLRs that may be due to random statistical variation. The credibility adjustment is added to the reported MLR calculation before calculating any remittance.

1) Contractor, Subcontractors, and Downstream Subcontractors may not add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible.

2) If Contractor's, Subcontractors, or Downstream Subcontractor's experience is non-credible, it is presumed to meet or exceed the MLR calculation standards in this Subsection.

3) Non-credible and partially-credible Contractors, Subcontractors, and Downstream Subcontractors that meet the materiality threshold must submit an MLR report regardless of credibility.

4) Contractor, Subcontractors, and Downstream Subcontractors must fulfill these requirements by using the base credibility factors that CMS publishes in accordance with 42 CFR section 438.8(h)(4).

5) Contractor must submit a MLR report regardless of credibility. DHCS may require MLR reporting by certain Subcontractors or Downstream Subcontractors regardless of credibility.

I. Contractor, Subcontractors, and Downstream Subcontractors must aggregate data by Member groups as defined in this Contract, or as otherwise directed by DHCS. This may require separate reporting and MLR calculations for specific populations.

J. Contractor must report its MLR to DHCS by county or rating region. Subcontractors and Downstream Subcontractors must report their MLR at the Subcontractor or Downstream Subcontractor arrangement level, by county or rating region, to their upstream entity.

K. MLR Reporting requirements.

1) Contractor, Subcontractors, and Downstream Subcontractors must submit a report to DHCS that includes at least the following information for each MLR reporting year:

a) Total incurred claims;

b) Expenditures on Quality Improvement activities;

c) Expenditures related to activities compliant with 42 CFR sections 438.608(a) – (5), (7), (8), and (b);

d) Non-claims costs;

e) Premium revenue;

f) Taxes, licensing, and regulatory fees;

g) Methodology(ies) for allocation of expenditures, which must include a detailed description of the methods used to allocate expenses, including incurred claims, quality improvement expenses, federal and State taxes and licensing or regulatory fees, and other non-claims costs, as described in 45 CFR section 158.170(b);

h) Any credibility adjustment applied;

i) The calculated MLR;

j) Any remittance owed to DHCS, if applicable;

k) A comparison of the information reported with the audited financial report required under 42 CFR section 438.3(m);

l) A description of the method used to aggregate data; and

m) The number of Member months.

2) Contractor must submit this report in a timeframe and manner determined by DHCS, but no longer than 12 months after the end of the MLR reporting year.

3) Contractor must require any Subcontractor or other third-party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to Contractor within 180 calendar days from the end of the MLR reporting year, or within 30 calendar days of being requested by Contractor, whichever is sooner, regardless of current contracting limitations, to calculate and validate the accuracy of MLR reporting.

4) Contractor must require Subcontractors impose reporting requirements equivalent to the information required in 42 CFR section 438.8(k) on Downstream Subcontractors who accept financial risk to perform delegated activities and reporting responsibilities specific for those services they do not directly provide to Members, in accordance with 42 CFR section 438.230(c)(1). Subcontractors must comply with all applicable Medi-Cal laws and regulations, including applicable sub-regulatory guidance and provisions of this Contract, in accordance with 42 CFR section 438.230(c)(2).

5) Contractor, Subcontractors, and Downstream Subcontractors must attest to the accuracy of the MLR calculation in accordance with requirements of this provision when submitting the MLR report.

6) Contractor must ensure Subcontractor submissions are in accordance with the information required in 42 CFR section 438.8(k). Contractor is expected to review and provide oversight of Subcontractor MLR submissions. Specific expectations include, but are not to be limited to:

   a) Review of each applicable Subcontractor's MLR and reported medical cost per Member per month to identify and investigate outliers;

   b) Review of reported expenses to ensure medical and non-medical expenses are appropriately accounted for in the MLR calculation;

   c) Verification that reported expenses align with service volume reported in encounters;

   d) Verification that reported revenues align with the upstream entities' reported payments;

   e) Review of the reasonableness of methodologies for allocation of expenditures across multiple lines of business;

   f) Review of the reasonableness of IBNR estimates.

Contractor will impose the aforementioned review and oversight expectations on Subcontractors and Downstream Subcontractors, as applicable, for their downstream entities. The contracts between all downstream entities in Contractor's delegation arrangement must include a reference to Exhibit A, Attachment III, Subsection 1.2.5.K.4 and 6 (*Medical Loss Ratio*).

L. Contractor may be excluded from the reporting requirements in this provision in the first MLR reporting year of its operation. Contractor then must comply with these requirements beginning with the next MLR reporting year in which it contracts with DHCS, even if the first MLR reporting year was not a full 12 months.

M. Consistent with 42 CFR section 438.8(l), Contractor may exempt newly contracted Subcontractors and Downstream Subcontractors from the MLR reporting requirements in the Subcontractor's or Downstream

Subcontractor's first MLR reporting year of its operation. Contractor then must require Subcontractors and Downstream Subcontractors to comply with the MLR reporting year requirements in the next reporting year even if the first MLR reporting year did not cover a full 12 months of operation.

1) Contractors must report any excluded Subcontractors and Downstream Subcontractors to DHCS by the end of the third quarter of that MLR reporting year utilizing DHCS' reporting form.

2) DHCS retains the discretion to reverse any exemption based on information obtained during the initial review of MLR reporting and/or subsequent State or federal reviews or audits. Contractor must comply, and must require their Subcontractors and Downstream Subcontractors to comply, with any such reversal and submit or amend MLR reporting as needed.

N. In any instance where DHCS makes a retroactive change to the Capitation Payments for a MLR reporting year and the MLR report has already been submitted to DHCS, Contractor must re-calculate the MLR for all MLR reporting years affected by the change and submit a new report meeting the reporting requirements in this Subsection.

O. Contractor must impose the above retroactive reporting requirements on its Subcontractors and Downstream Subcontractors where DHCS makes a retroactive change to the Capitation Payments for a MLR reporting year and the MLR report has already been submitted to Contractor or upstream Subcontractor. In its sole discretion, DHCS reserves the right to limit MLR re-reporting for Subcontractors and Downstream Subcontractors to no more than one instance and may require re-reporting on an ad hoc basis. Subcontractors and Downstream Subcontractors must not re-report a MLR more than once for any MLR reporting year absent DHCS' review and express permission for any such MLR re-reporting. DHCS has the sole authority and discretion to grant or deny permission to any request for a Subcontractor or Downstream Subcontractor to re-report more than once for any MLR reporting year. The contracts between all downstream entities in Contractor's delegation arrangement must include this reference.

P. Contractor must, if applicable, provide a remittance for a MLR reporting year in accordance with W&I section 14197.2(c)(1) and Exhibit B of this Contract. Starting January 1, 2025, Contractor must impose equivalent remittance requirements on Subcontractors and Downstream Subcontractors.

Q. In accordance with the CalAIM 1915(b) Waiver STCs, DHCS will work with CMS to effectuate an audit of MLR reports no sooner than the 2028

calendar year. The MLR audit will include the time period covered by the CalAIM 1915(b) Waiver (January 1, 2022 through December 31, 2026).

1) To allow DHCS and CMS to complete an accurate audit of the MLR reports, Contractors, Subcontractors, and Downstream Subcontractors must maintain all records and documents relating to MLR reports for a minimum of 10 years as described in 42 CFR section 438.3(u).

2) Pursuant to 42 CFR section 438.3(h), DHCS and its contractor(s) may, at any time, request, inspect, and audit any of Contractor's, Subcontractors', and Downstream Subcontractors' records or documents. Record retention requirements are also referenced in Exhibit E of this Contract.

1.2.6 Contractor's Obligations

A. Contractor is required to provide any other financial reports, data, or information not listed above as requested by DHCS to evaluate or monitor Contractor's financial condition.

B. If Contractor's incurred claims reported in accordance with Exhibit A, Attachment III, Subsection 1.2.5, Paragraph C.1.a.iii above includes withholds from payments made to Network Providers, Contractor must provide to DHCS a report, in a form and manner specified by DHCS, detailing the basis for those withholds.

1.2.7 Community Reinvestment Plan and Report

A. Contractor must annually submit a Community Reinvestment Plan for DHCS' approval that details its anticipated community reinvestment activities, pursuant to Exhibit B, Section 1.1.17 (*Community Reinvestment*), in a form and manner specified by DHCS through APLs or similar guidance. The Community Reinvestment Plan must include information and any supporting documentation requested by DHCS through APLs or similar guidance. DHCS will make available the parameters for allowable community reinvestment activities through APLs or similar guidance.

B. If Contractor has a Subcontractor subject to community reinvestment requirements pursuant to Exhibit B, Subsection 1.1.17 (*Community Reinvestment*) based on criteria established by DHCS through APLs or similar guidance, Contractor must annually request from Subcontractor and incorporate applicable Community Reinvestment Plan in the submission to DHCS pursuant to Exhibit A, Attachment III, Subsection 1.2.7(A).

C. Contractor must submit a Community Reinvestment Report, including information related to any Subcontractor subject to community reinvestment requirements pursuant to Exhibit B, Subsection 1.1.17 (Community Reinvestment) based on criteria and timelines established by DHCS through APLs or similar guidance, in a form and manner specified by DHCS through APLs or similar guidance. The Community Reinvestment Report must detail Contractor's community reinvestment activities in accordance with the Community Reinvestment Plan, and the outcomes thereof. DHCS will make available the minimum information requirements for the report through APLs or similar guidance.

Exhibit A, ATTACHMENT III

1.3 Program Integrity and Compliance Program

1.3.1 Compliance Program
1.3.2 Fraud Prevention Program
1.3.3 Provider Screening, Enrolling, and Credentialing/Recredentialing
1.3.4 Contractor's Obligations Regarding Suspended, Excluded, and Ineligible Providers
1.3.5 Disclosures
1.3.6 Treatment of Overpayment Recoveries
1.3.7 Federal False Claims Act Compliance and Support

1.3 Program Integrity and Compliance Program

Contractor must establish administrative and management policies and procedures which are designed to prevent and detect Fraud, Waste, and Abuse. In furtherance of this goal, Contractor must establish a Compliance program, a Fraud, Waste, and Abuse prevention program, and other program integrity processes, as set forth in this Exhibit A, Attachment III, Section 1.3 (*Program Integrity and Compliance Program*). In establishing these policies, procedures, and programs, Contractor must meet the requirements of 42 Code of Federal Regulations (CFR) section 438.608.

While Contractor may contract with entities to support Contractor on compliance activities (such as training and auditing), Contractor may not delegate program integrity and compliance program functions to Subcontractors or Downstream Subcontractors.

Contractors must ensure that all Subcontractors and Downstream Subcontractors also have a robust program integrity and compliance program in place. This requirement may be fulfilled by Contractor maintaining all program integrity and compliance program functions on behalf of Subcontractor or Downstream Subcontractor.

1.3.1 Compliance Program

Contractor must have a compliance program that includes, at a minimum, the following elements:

A. A compliance plan which:

1) Outlines the key elements of the compliance program;

2) Includes reference to the standards of conduct or code of conduct;

3) Allows the compliance program to act independently of operational and program areas without fear of repercussions for uncovering deficiencies or noncompliance;

4) Details how it will implement and maintain elements of the compliance program;

5) Includes the compliance reporting structure and positions of key personnel involved in ensuring compliance, including the compliance officer;

6) References the delegation reporting and compliance plan;

7) References policies and procedures operationalizing the compliance program;

8) Is reviewed and approved by the board of director's compliance and oversight committee routinely, but not less than annually; and

9) Is publicly posted on Contractor's website.

B. Standard of conduct or code of conduct must clearly articulate Contractor's commitment to comply with all applicable requirements and standards under this Contract, and all applicable federal and State requirements. It must describe the organizational expectations that all employees, officers, board of directors, Network Providers, Subcontractors, and Downstream Subcontractors act ethically and have a responsibility in ensuring compliance. Standard of conduct must be approved by Contractor's full board of directors annually.

C. Written policies and procedures which address the following:

1) Detail how elements of the compliance program are operationalized, including the titles of persons responsible for specific activities;

2) Describe how Contractor will oversee all Network Providers, Subcontractors, Downstream Subcontractors, and third-party entities compliance with all applicable terms and conditions of the Contract. See also, Exhibit A, Attachment III, Subsection 3.1.4 (*Contractor's Duty to Ensure Subcontractor, Downstream Subcontractor, and Network Provider Compliance*); and

3) Outline Contractor's process to ensure policies and procedures are reviewed at least annually and how changes are disseminated to impacted operational areas. Contractor must update the policies and procedures to incorporate changes in applicable laws, regulations, and requirements.

D. A delegation reporting and compliance plan as described in Exhibit A, Attachment III, Subsection 3.1.3 (*Contractor's Duty to Disclose All Delegated Relationships and to Submit Delegation Reporting and Compliance Plan*) and Exhibit J *(Delegation Reporting and Compliance Plan)*.

E. The designation of a compliance officer who is responsible for developing, implementing, and ensuring compliance with the requirements and standards under the Contract and who reports directly to the chief executive officer and the board of directors. Contractor's policies and

procedures must include the criteria for selecting a compliance officer and a job description, including responsibilities and the authority of this position. The compliance officer must be a full-time employee and must be independent, which means they must not serve in both a compliance and operational role, for example, when the compliance officer is the chief operating officer, finance officer or general counsel.

F. The establishment of a regulatory compliance and oversight committee of the board of directors and at the senior management level charged with overseeing Contractor's compliance program and compliance with the requirements under this Contract. Contractor's policies and procedures must include the criteria for selecting members to the committee. The committee must review the compliance plan on an annual basis. The committee must meet at least quarterly to oversee the compliance program, including, reviewing areas of non-compliance and implementation and monitoring of Corrective Actions.

G. A system for training and educating the compliance officer, senior management, and employees on federal and State standards and requirements of this Contract. Trainings must address Contractor's standards of conduct, compliance plan, and compliance policies and procedures compliance training completion must be verified such as through a certification or attestation upon training completion and review of the standard of conduct, compliance program, and compliance policies and procedures. Contractor must ensure that training for the compliance officer, senior management, and employees on the compliance program is completed within 90 days of employment and annually thereafter.

H. A system for board members, officers, senior management, and employees to receive training on policies and procedures related to compliance for specific job functions including but not limited to:

1) Compliance officer, senior management, and employees training and education on the overall compliance program, Fraud, Waste, and Abuse, and code of conduct in accordance with Exhibit A, Attachment III, Section 1.3 (*Program Integrity and Compliance Plan*);

2) Network Providers completion of required initial and ongoing Network Provider training within the established timeframes in accordance with Exhibit A, Attachment III, Subsection 3.2.5 (*Network Provider Training*), Members' rights as required under Exhibit A, Attachment III, Section 3.2 (*Provider Relations*), and Advanced Directives in accordance with 42 CFR sections 422.128 and 438.3(j) set forth in Exhibit A, Attachment III, Subsection 5.1.1 (*Members Rights and Responsibilities*);

3) Member Services staff completion of required training as set forth in Exhibit A, Attachment III, Subsection 5.1.2 (*Member Services Staff*) and include diversity, equity and inclusion training in accordance with Exhibit A, Attachment III, Subsection 5.2.11.C. (*Cultural and Linguistic Programs and Committees*); and

4) For staff carrying out obligations under MOUs, the training required under Exhibit A, Attachment III, Section 5.6 (*MOUs with Local Government Agencies, County Programs, and Third Parties*)

I. Effective lines of communication between the compliance officer and employees. For example, Contractor must establish a consistent process for distributing and communicating new regulations, regulatory changes, or changes relevant to this Contract. Contractor will communicate this process to all Subcontractors, Downstream Subcontractors, and Network Providers, as applicable. Lines of communication must be accessible to all employees and include a mechanism to enable anonymous and confidential good faith reporting of potential compliance issues by any employee, Member, Network Provider, Subcontractor, or other person or entity, as they are identified.

J. Enforcement of standards through well-publicized disciplinary guidelines. This includes, but is not limited to:

1) Establishment and implementation of disciplinary policies and procedures that reflect clear and specific disciplinary standards as well as Contractor's expectation for reporting of issues related to noncompliance or illegality; training expectations and disciplinary or enforcement standards when noncompliant activity is found.

2) To demonstrate that disciplinary guidelines are enforced, Contractor must maintain records of disciplinary actions for a period of ten years at a minimum, including date of and description of violation, date of investigation, findings and date and description disciplinary action.

K. Contractor must develop and maintain effective systems for routine monitoring and auditing, and identification of compliance risks including but not limited to:

1) Dedicated staff for routine internal monitoring and auditing of compliance risks;

2) Methods and tools for assessing whether Contractor activities required under this Contract comply with State and federal law and

this Contract. This includes having methods and tools to evaluate and trend an activity over time to assess noncompliance;

3) Routine and periodic reporting of internal monitoring and auditing activities and results to compliance and oversight committee of the board; and

4) Unannounced audits of Subcontractors and Downstream Subcontractors to assess the compliance with requirements set forth in this Contract as relevant to delegated functions.

L. Contractor must develop and maintain effective systems for prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under this Contract (42 CFR section 438.608(a)).

1) This includes policies and procedures for constructing and implementing effective Corrective Action plans, including root cause analysis and tailoring Corrective Action plans to address specific compliance concerns;

2) Corrective action plans must be reviewed and signed by the compliance officer and the executive officer responsible for the area subject to the Corrective Action plan;

To demonstrate effective systems to address compliance concerns and implement effective corrective action, Contractor must maintain and publicly post records of Corrective Action plans and the rectifying actions to close out the findings, including but not limited to, committee meeting minutes detailing discussion of corrective action plans and description of outcomes; and

3) Contractor must ensure contractual provisions are in place through Subcontractor Agreements and Downstream Subcontractor Agreements, as relevant, to enforce compliance with Corrective Action plans when they are not met, such as financial sanctions, payment withholds, or liquidated damages.

1.3.2 Fraud Prevention Program

Contractor must have a Fraud prevention program that at a minimum sets forth policies and procedures for the elements identified in this Exhibit A, Attachment III, Subsection 1.3.2 (*Fraud Prevention Program*).

A. Fraud Prevention Officer

Contractor must designate a Fraud prevention officer who is responsible for developing, implementing, and ensuring compliance with Contractor's Fraud prevention program and who reports directly to the chief executive officer and the board of directors. The Fraud prevention officer must attend and participate in DHCS' quarterly program integrity meetings, as scheduled. The same individual may serve as both the compliance officer and the Fraud prevention officer.

B. Notification of Changes in Member's Circumstances

Contractor must promptly notify its local county office when Contractor receives information about changes in a Member's circumstances that may affect the Member's eligibility including changes in the Member's residence or death of a Member (42 CFR section 438.608(a)(3)). This notification will be in a form and manner specified by DHCS through All Plan Letters (APLs), or other similar instructions.

C. Method to Verify Services Received

Contractor must have a regular method to verify, by sampling or other methods, confirming that services that have been represented to have been delivered by Network Providers were received by Members (42 CFR section 438.608(a)(5)). Contractor must provide proof of compliance with this requirement when requested by DHCS, in a form and manner specified by DHCS through APLs, or other similar instruction.

D. Contractor's Reporting Obligations

In accordance with 42 CFR section 438.608(a)(7), Contractor must refer, investigate, and report all Fraud, Waste, and Abuse activities that Contractor identifies to DHCS' Program Integrity Unit (PIU), in a manner prescribed by PIU, as follows:

1) Preliminary Fraud, Waste, and Abuse Reports

Contractor must file a preliminary report with DHCS' PIU detailing any suspected Fraud, Waste, or Abuse identified by or reported to Contractor, its Subcontractors, its Downstream Subcontractors, and/or its Network Providers within ten Working Days of Contractor's discovery or notice of such Fraud, Waste, or Abuse. Contractor must submit a preliminary report in accordance with requirements set forth in APLs or other similar instructions. Subsequent to the filing of the preliminary report, Contractor must

promptly conduct a complete investigation of all reported or suspected Fraud, Waste, and Abuse activities.

2) Completed Investigation Report

Within ten Working Days of completing its Fraud, Waste, or Abuse investigation (including both Contractor-initiated and DHCS-initiated referrals), Contractor must submit a completed report to DHCS' PIU. This report must include Contractor's findings, actions taken, and include all documentation necessary to support any action taken by Contractor, and any additional documentation as requested by DHCS or other State and federal agencies.

3) Quarterly Fraud, Waste, Abuse Status Report

Contractor must submit a quarterly report to DHCS' PIU on all Fraud, Waste, and Abuse investigative activities ten Working Days after the close of every calendar quarter. The quarterly report must contain the status of all preliminary, active, and completed investigations and must include both Contractor-initiated and DHCS-initiated referrals. In addition to quarterly reports, Contractor must provide updates and available documentation as DHCS may request from time to time.

4) Manner of Report Submission

Contractor must electronically submit each Fraud, Waste, and Abuse report required under the Contract in a manner prescribed by DHCS' PIU. The required reports must include but not be limited to the preliminary Fraud report, the completed investigation report, and the quarterly status report, including all supporting documents, and any additional documents requested by DHCS, in a form and manner specified by DHCS through APLs, or other similar instructions.

5) Contractor's Obligation to Investigate State, federal, and other Medi-Cal managed care plans' Referrals of Fraud, Waste, and Abuse.

DHCS may, from time to time, share with Contractor relevant Fraud, Waste, and Abuse referrals received from State and federal agencies and other Medi-Cal managed care plans. Contractor may also receive Fraud, Waste, and Abuse referrals directly from other federal agencies, State agencies (other than DHCS), and Medi-Cal managed care plans.

Contractor must conduct a complete investigation of all Fraud, Waste, and Abuse referrals received from DHCS, other State and federal agencies, and other Medi-Cal managed care plans, relating to Contractor's Subcontractors, Downstream Subcontractors, and Network Providers. Contractor must submit a completed investigation report and a quarterly status report, as set forth above in this Exhibit A, Attachment III, Subsection 1.3.2.D (*Contractor's Reporting Obligations*), in connection with all DHCS, State and federal agency, and Medi-Cal managed care plan referrals of Fraud, Waste, and Abuse.

6) Confidentiality

Contractor acknowledges that information shared by DHCS, other State and federal agencies, and other Medi-Cal managed care plans in connection with any Fraud, Waste, or Abuse referral must be considered confidential, until formal criminal proceedings are made public. Contractor further acknowledges that it is receiving this Confidential Information as a DHCS business associate in order to facilitate Contractor's contractual obligations to maintain a Fraud, Waste, and Abuse prevention program. Contractor must receive and maintain this Confidential Information in its capacity as a Medi-Cal managed care plan and will use the Confidential Information only for conducting an investigation into any potential Fraud, Waste, or Abuse activities and in furtherance of any other program integrity activities.

In the event Contractor is required to share this Confidential Information with a Subcontractor, Downstream Subcontractor, or Network Provider, Contractor must ensure that Subcontractor, Downstream Subcontractor and Network Provider acknowledge that such information must be kept confidential by Subcontractor, Downstream Subcontractor, and Network Provider, and a similar provision of confidentiality must be included in all Subcontractor Agreements, Downstream Subcontractor Agreements, and Network Provider Agreements.

1.3.3 Provider Screening, Enrolling, and Credentialing/Recredentialing

A. Screening and Enrolling

All Network Providers must be screened and enrolled in accordance with this Contract, applicable State and federal law, including 42 CFR section 438.602(b), and APL 22-013.

1) If Contractor chooses not to utilize the State level Enrollment pathway, Contractor must notify DHCS and send to DHCS its policies and procedures for review and approval before conducting its own Enrollment process.

2) Contractor may allow Network Providers to participate in their Network for up to 120 calendar days if the Network Provider has a pending Enrollment application in review with DHCS or with Contractor in accordance with 42 CFR section 438.602(b)(2).

3) Contractor must terminate its contract with the provider no later than 15 calendar days of the provider receiving notification from DHCS that the provider has been denied Enrollment in the Medi-Cal program, or upon the expiration of the first 120-day period. Contractor cannot continue to contract with providers during the period in which the provider resubmits its Enrollment application to DHCS or Contractor and can only re-initiate a contract upon the provider's successful enrollment.

B. Credentialing/Recredentialing

Contractor has an on-going obligation to credential and recredential Providers and Network Providers in accordance with this Contract (Exhibit A, Attachment III, Subsection 2.2.13 (*Credentialing and Recredentialing*)), applicable State and federal law, including 42 CFR section 438.602(b), and APL 22-013.

1.3.4 Contractor's Obligations Regarding Suspended, Excluded, and Ineligible Providers

Contractor has a continuing obligation to verify that Contractor's Network Providers are enrolled and remain enrolled in the Medi-Cal program. Contractor is responsible for knowledge of all ineligible Providers and individuals on these lists.

A. Tracking Suspended, Excluded, and Ineligible Providers

Contractor must review the following exclusionary databases and lists no less frequently than monthly and take appropriate action in accordance with APL 15-026 and APL 21-003.

1) List of Suspended and Ineligible Providers located at https://www.medi-cal.ca.gov;

2) List of excluded individuals and entities maintained by the U.S. Department of Health and Human Services (U.S. DHHS), Office of Inspector General located at https://oig.hhs.gov;

3) The System of Award Management (SAM);

4) The Social Security Administration Death Master File (SSADMF);

5) To the extent applicable, National Plan and Provider Enumeration System (NPPES); and

6) Restricted Provider Database

Contractor must notify DHCS' PIU within ten Working Days of removing a suspended, excluded, or ineligible Providers or individual from its Network and confirm that the ineligible Provider is no longer receiving payments, either directly or indirectly, in connection with the Medi-Cal program. A suspended, excluded, and ineligible Provider report must be sent to DHCS PIU in a manner prescribed by DHCS' PIU.

B. No Contracts with Excluded, Suspended, or Ineligible Providers

Contractor is prohibited from employing, paying, contracting, or maintaining a Medi-Cal contract with Providers that are excluded, suspended, or ineligible to participate, either directly or indirectly, in the Medicare or Medi-Cal programs (42 CFR section 438.610(a)-(c) and APL 21-003), for services other than Emergency Services, as described in Exhibit A, Attachment III, Subsection 3.1.5 (*Requirements for Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements*); Exhibit A, Attachment III, Subsection 3.3.18 (*Prohibition Against Payment to Excluded Providers*); and 42 USC section 1396b(i)(2).

C. Notification and Termination of Contracts

Contractor must promptly notify DHCS when Contractor receives information about a change in a Network Provider's, Subcontractor's, or Downstream Subcontractor's circumstances that may affect the Network Provider's, Subcontractor's, or Downstream Subcontractor's eligibility to participate in the Medi-Cal managed care program, including the termination of their Network Provider Agreement, Subcontractor Agreement, or Downstream Subcontractor Agreement with Contractor in accordance with this Contract, State and federal law, including 42 CFR section 438.608(a)(4), and APL 21-003.

D. Actions to be taken where Credible Allegation of Fraud

If DHCS, Division of Medi-Cal Fraud and Elder Abuse (DMFEA), or United States Department of Justice (US DOJ), or any other authorized State or federal agency, determines there is a credible allegation of Fraud against Contractor's Subcontractor, Downstream Subcontractor, or Network Provider, Contractor must comply with this Contract, all applicable State and federal laws, APL 15-026, and APL 21-003. Contractor must have procedures in place to immediately suspend payments to Subcontractors, Downstream Subcontractors, and Network Providers for which a State or federal agency determines there is a credible allegation of Fraud (42 CFR section 438.608(a)(8)). In addition, Contractor may conduct additional monitoring, temporarily suspend, and/or terminate the Network Provider, Subcontractor, or Downstream Subcontractor.

1.3.5 Disclosures

In accordance with 42 CFR section 438.608(c), Contractor, its Subcontractors, and its Downstream Subcontractors must:

A. Provide written disclosure of any prohibited affiliation under 42 CFR section 438.610; and

B. Provide written disclosures of information on ownership and control as required under 42 CFR section 455.104.

C. Report and return any payment to DHCS within 60 calendar days of when it has identified any Capitation Payments or other payments it has received or paid in excess of the amounts specified in this Contract.

1.3.6 Treatment of Overpayment Recoveries

A. Retention, Reporting, and Payment of Recoveries

1) Contractor must comply with guidelines issued by DHCS pertaining to the treatment of recoveries of all overpayments from Contractor to a Provider, including for the treatment of recoveries of overpayments due to Fraud, Waste, or Abuse. Contractor must also comply with the process, timeframes, and documentation required for reporting to DHCS the identification or recovery of overpayments by Contractor, as set forth in APL or other guidance. Within 30 calendar days, Contractor must report to its Managed Care Operations Division (MCOD) Contract Manager (CM) and the DHCS Audits and Investigations Unit all identified or recovered overpayments to Subcontractors, Downstream Subcontractors, Network Providers, and/or Providers of Medi-Cal services, medical

supplies, or drugs, specifying any overpayments due to potential Fraud, in the manner set forth in APL 23-011. This requirement applies regardless of the overpayment amount and the reason for the overpayment. Contractor must report all overpayments within 30 calendar days of the identification of the overpayment. If Contractor eventually recovers the overpayment, it must separately report the recovered overpayment within 30 calendar days of the recovery.

2) Contractor may retain overpayment recoveries from Subcontractors, Downstream Subcontractors, Network Providers, and/or Providers of Medi-Cal services, medical supplies, or drugs associated with overpayments that Contractor identifies if Contractor reports the overpayment to DHCS within 30 calendar days of when it first identifies the overpayment. Consistent with 42 CFR section 438.608(d)(1)(iv), this provision does not apply to any amount of a recovery to be retained under False Claims Act cases or when DHCS, CMS, DMFEA, federal or state departments of justice, federal or state Inspectors General, or their agent or designee, identify and/or recover overpayments through their audits or investigations. When the subject of Contractor's identified overpayment is under audit or investigation by a state or federal agency, DHCS may recover such overpayment as set forth in Exhibit B, Subsection 1.1.9 (Recovery of Amounts Paid to Contractor) or, at its sole discretion, may permit Contractor to retain overpayment recoveries.

3) If DHCS, CMS, DMFEA, federal or state departments of justice, federal or state Inspectors General, or their agent or designee, identifies, whether through audit, investigation, or otherwise, that Contractor has made an overpayment (whether erroneous, improper, or otherwise) to any Subcontractors, Downstream Subcontractors, Network Providers, and/or Providers of Medi-Cal services, medical supplies, or drugs that Contractor has not previously identified and reported to DHCS within 30 calendar days of its identification, may recover such as set forth in Exhibit B, Subsection 1.1.9 (*Recovery of Amounts Paid to Contractor*).

4) Contractor must comply with this Contract, and all applicable State and federal law regarding overpayment recoveries, including 42 CFR sections 438.608(a)(2) and (d).

5) Contractor is required to report all identified or recovered overpayments in their annual report to DHCS, using the rate

development template or in another manner specified by DHCS, in accordance with 42 CFR section 438.608(d)(3).

1.3.7 Federal False Claims Act Compliance and Support

A. Employee Education about False Claims Recovery

Contractor must provide to all its employees, Subcontractors, Downstream Subcontractors, and Network Providers written policies containing detailed information about the False Claims Act and other federal and State laws described in 42 United States Code (USC) section 1396a(a)(68), including information about rights of employees to be protected as whistleblowers (See also 42 CFR section 438.608(a)(6)).

Upon request by DHCS, Contractor must demonstrate compliance with this Exhibit A, Attachment III, Subsection 1.3.7.A (*Employee Education about False Claims Recovery*), which may include providing DHCS with copies of Contractor's applicable written policies and procedures and any relevant employee handbook excerpts.

B. Cooperation with the Office of the Attorney General, DMFEA, or the US DOJ Investigations and Prosecutions.

Contractor must fully cooperate in any investigation or prosecution conducted by the Office of the Attorney General, DMFEA or the US DOJ. Contractor's cooperation must include, but is not limited to, providing upon request, information, and access to records. Contractor is also responsible for making their staff available for in-person interviews, consultation, grand jury proceedings, pre-trial conference, depositions, and hearings at DHCS headquarters in Sacramento.

C. Money Recovered from State Action Belongs to the State

In the event that DHCS receives a monetary recovery from the Office of the Attorney General, DMFEA, or the US DOJ, as a result of DMFEA's or US DOJ's prosecution of a Subcontractor, Downstream Subcontractor, or Network Provider under the California False Claims Act (Government Code (GC) § 12650 *et seq.*), the Federal False Claims Act (31 USC section 3729 *et seq.*), or any other applicable laws, the entirety of such monetary recovery belongs exclusively to DHCS, and Contractor waives any claim to any portion of the recovery, except as determined by DHCS in its sole discretion.

D. Payment to Contractor is from Government Funds

Medi-Cal payments to Contractor, Subcontractors, Downstream Subcontractors, Network Providers, and Providers are made from federal and State government funds. DHCS retains the right to recover overpayments made to Contractor, Subcontractors, Downstream Subcontractors, Network Providers, and/or Providers of Medi-Cal services, medical supplies, or drugs, including such overpayments made by Contractor to Subcontractors, Downstream Subcontractors, Network Providers, and/or Providers of Medi-Cal services, medical supplies, or drugs, as set forth in part in Exhibit A, Subsection 1.3.6 (*Treatment of Overpayment Recoveries*) and Exhibit B, Section 1.9 (*Recovery of Amounts Paid to Contractor*). In addition to DHCS' recovery rights, DMFEA and US DOJ may prosecute any act of health care Fraud involving such government funds under the California False Claims Act (GC § 12650 *et seq.*), the Federal False Claims Act (31 USC section 3729 *et seq.*), or any other applicable laws.

E. Contractor's Settlements with Subcontractors, Downstream Subcontractors, and Network Providers do not bind DHCS, DMFEA, or the US DOJ.

Any settlement or resolution of a disputed matter involving Fraud, Waste, or Abuse between Contractor and its Subcontractor, Downstream Subcontractor, or Network Provider must include a written provision that provides notice to the Subcontractor, Downstream Subcontractor, or Network Provider that the settlement and/or resolution is not binding on DHCS, DMFEA, or the US DOJ and does not preclude DHCS, DMFEA, or the US DOJ from taking further action against Contractor or its Subcontractor, Downstream Subcontractor, or Network Provider.

Exhibit A, ATTACHMENT III

2.0 Systems and Processes

DHCS is committed to ensuring Contractors have the capabilities, systems and processes that enable delivery of high-quality health care. The provisions in this Article lay out DHCS' expectations of Contractors to have Management Information Systems (MIS) to collect, report, and analyze data to identify Members' needs and support Population Health Management. Contractors must be able to not only submit Encounter Data, but have systems to ensure the data are complete, accurate, reasonable, and timely, including for Subcontractors, Downstream Subcontractors, and Network Providers.

The provisions of this Article are also intended to ensure that Medi-Cal systems and processes are innovative and adapting to the way in which Members seek and access care. DHCS expects Contractors to build upon their MIS capabilities to enable interoperability for data exchange with Health Information Technology (HIT) systems and Health Information Exchange (HIE) Networks. Further, Contractors must comply with the Centers for Medicare & Medicaid Services (CMS) Interoperability and Patient Access Final Rule set forth at CMS-9115-F and ensure that they and their Subcontractors, Downstream Subcontractors, and Network Providers have the system capabilities to comply with the California Health and Human Services Data Exchange Framework set forth in H&S section 130290 and APL or other guidance. These requirements will enable the delivery system to have information for Members where and when they need care.

To further drive standards of high quality care and Health Equity, this Article includes provisions requiring Contractors to have both National Committee for Quality Assurance (NCQA) Health Plan Accreditation and Health Equity Accreditation by January 1, 2026. Further, DHCS specifies alignment of Quality Improvement and Health Equity activities that align in principle with the DHCS Comprehensive Quality Strategy and imposes requirements for Contractors to meet or exceed minimum performance standards.

DHCS is committed to transparency to demonstrate accountability to the public and community it serves. Consequently, DHCS requires public reporting of information related to access, quality, delegation, quality improvement, and Health Equity activities. Specific to public posting, this Article includes provisions requiring Contractors to make available on their websites their annual Quality Improvement and Health Equity Transformation Plan, meeting minutes from their Quality Improvement and Health Equity Committee (QIHEC), and Utilization Management policies and procedures.

2.1 Management Information System

2.1.1 Management Information System Capability
2.1.2 Encounter Data Reporting
2.1.3 Participation in the State Drug Rebate Program
2.1.4 Network Provider Data Reporting
2.1.5 Program Data Reporting
2.1.6 Template Data Reporting
2.1.7 Management Information System/Data Audits
2.1.8 Management Information System/Data Correspondence
2.1.9 Tracking and Submitting Alternative Format Selections
2.1.10 Interoperability Application Programming Interface System Requirements

2.1 Management Information System

2.1.1 Management Information System Capability

Contractor's Management and Information System (MIS) must be fully compliant with 42 Code of Federal Regulations (CFR) section 438.242 requirements and must have the capability to capture, edit, and utilize various data elements for both internal management use as well as to meet the data quality and timeliness requirements of DHCS's Encounter Data submission. Contractor must make available to DHCS and to the Centers for Medicare & Medicaid Services (CMS) upon request all data related to this Contract.

A. Contractor must have and maintain a MIS that supports, at a minimum:

1) All Medi-Cal eligibility data;

2) Information on Members enrolled with Contractor;

3) Provider claims status and payment data;

4) Health care services delivery Encounter Data;

5) Network Provider Data;

6) Program Data;

7) Template Data;

8) Screening and assessment data;

9) Referrals including tracking of referred services to follow up with Members to ensure that services were rendered;

10) Electronic health records;

11) Prior Authorization requests and a specialty referral system as specified in Exhibit A, Attachment III, Section 2.3 (*Utilization Management Program*);

12) Complex Care Management (CCM) Care Manager assignment as specified in Exhibit A, Attachment III, Subsection 4.3.7 (*Care Management Programs*);

13) Financial information as specified in Exhibit A, Attachment III, Subsection 1.2.2 (*Contractor's Financial Reporting Obligations*);

14) Social Drivers of Health (SDOH) data per All Plan Letter (APL) 21-009;

15) Member and Member's Authorized Representative (AR) Alternative Format Selection(s) (AFS); and

16) Data sources specified in DHCS policies and guidance, including APLs, the Enhanced Care Management (ECM) Policy Guide, Community Supports Policy Guide, the Population Health Management (PHM) Policy Guide, and the Policy and Operational Guide for Planning and Implementing CalAIM Justice-Involved Re-entry Initiative.

B. Contractor's MIS must have processes that support the interactions between financial data, Member/eligibility data, Network Provider Data, Encounter Data, claims data, Program Data, Template Data, quality management/quality improvement/Utilization Management data, and report generation subsystems. The interactions of Contractor's MIS subsystems must be interoperable, efficient, and successful with Contractor's other MIS subsystems and DHCS' systems and processes.

C. Contractor's MIS must have the capability to transmit and consume data files with and from DHCS, Subcontractors, Downstream Subcontractors, Network Providers, other State and federal and local governmental agencies, and other sources as needed to support Care Coordination and overall administration of the Medi-Cal program. Data that must be able to be transmitted and consumed include, but are not limited to:

1) Encounter Data;

2) Fee-For-Service (FFS) claims data; including carved-out claims data, such as Medically Necessary services carved out of this Contract and data available from partner organizations, including but not limited to the Local Education Agency Medi-Cal Billing Option Program (LEA BOP) and incarceration in-reach services;

3) Dental claims data;

4) Specialty mental health data;

5) Substance Use Disorder (SUD) data;

6) Medi-Cal FFS Treatment Authorization Request data;

7) California Children's Services (CCS) Program data;

8) Targeted Case Management (TCM) data;

9) Pharmacy claims data;

10) Risk Tier assignment data;

11) Authorization and referral data; and

12) Medical record information including case notes.

Contractor must have processes in place for utilizing all data made available in order to meet the requirements for and support of Care Coordination, other administrative functions of the Contract with DHCS, and Operational Readiness Requirements and Deliverables as described in Exhibit A, Attachment II.

D. Contractor must implement and maintain a publicly accessible, standards-based Patient Access Application Programming Interface (API), and a Provider Directory API, as described in 42 CFR sections 431.60 and 431.70, and in APL 22-026. Contractor must operate the API in the manner specified in 45 CFR section 170.215 and include information per 42 CFR section 438.242(b)(5) and (6).

2.1.2 Encounter Data Reporting

A. Contractor must maintain a MIS that consumes Encounter Data and/or claims data and transmits Encounter Data, including allowed amounts and paid amounts as required, to DHCS in compliance with 42 CFR sections 438.242 and 438.818 and in accordance with APLs.

B. Contractor must implement policies and procedures for ensuring the complete, accurate, reasonable, and timely submission of Encounter Data to DHCS, as defined in State and federal law, APLs, and this Contract, for all items and services furnished to a Member under this Contract, whether directly or through Subcontractor Agreements, Downstream Subcontractor Agreements, or Network Provider Agreements.

C. Contractor must require all Network Providers, Subcontractors, Downstream Subcontractors, and out-of-Network Providers to submit claims and Encounter Data to Contractor to ensure compliance with this Contract. Contractor must have mechanisms, including edit and reporting systems, sufficient to ensure Encounter Data is complete, accurate, reasonable, and timely, as defined in State and federal law and APLs, prior to submission to DHCS. Contractor must ensure the completeness, accuracy, reasonableness, and timeliness of all Network Provider, Subcontractor, Downstream Subcontractor, and out-of-Network Provider

Encounter Data regardless of contracting arrangements or whether the Network Provider, Subcontractor, Downstream Subcontractor, or out-of-Network Provider is reimbursed on a FFS or capitated basis.

D. Contractor must submit complete, accurate, reasonable, and timely Encounter Data within six Working Days of the end of each month following the month of payment, under this Contract or as otherwise agreed upon by DHCS, and in the format specified by DHCS.

E. DHCS will review and validate Contractor's Encounter Data, including Encounter Data submitted by Contractor on behalf of its Subcontractors, Downstream Subcontractors, and Network Providers, for completeness, accuracy, reasonableness, and timeliness.

F. If DHCS finds deficiencies regarding the completeness, accuracy, reasonableness, or timeliness of Contractor's Encounter Data and notifies Contractor in writing of the deficiencies and requests correction and resubmission of the relevant Encounter Data, Contractor must ensure that corrected Encounter Data is resubmitted within 15 calendar days of the date of DHCS' notice, or as mandated through federal law. Upon Contractor's written request, DHCS may, in its sole discretion, grant an extension for submission of corrected Encounter Data.

G. DHCS or its agent will periodically, but not less frequently than once every three years, conduct an independent audit of the Encounter Data submitted by, or on behalf of, Contractor, in accordance with 42 CFR section 438.602(e). Contractor must comply with the requirements set forth in Exhibit A, Attachment III, Subsection 2.2.9.E (*Encounter Data Validation*).

2.1.3 Participation in the State Drug Rebate Program

A. Contractor must participate in the federal and State drug rebate program by including all utilization data for both current and retroactive outpatient drugs in its Encounter Data as necessary to meet federal requirements in 42 United States Code (USC) section 1396r - 8(k)(2).

1) Encounter Data for outpatient drugs must comply with 42 USC section 1396r - 8(b)(1)(A); and

2) All outpatient drug Encounter Data must include, at a minimum, the total number of units of each dosage form, strength, and package size, by 11 numeric digit National Drug Code (NDC), for each claim, including eligible Physician administered drug claims.

B. Pursuant to 42 CFR section 438.3(s), Contractor must ensure that Encounter Data for outpatient drugs from participating organizations or covered entities in the federal 340B program contains DHCS-required identifiers to maintain compliance with the requirements of 42 USC section 256b(a)(5)(A)(i). Contractor must also comply with the provisions of Welfare and Institutions Code (W&I) section 14105.46.

C. Contractor must assist DHCS in resolving manufacturer rebate disputes related to Network Provider Data or Encounter Data submissions. Encounter Data identified by DHCS or Contractor as having inaccurate or incomplete units, NDCs, procedure codes, 340B identifiers, or other data elements necessary to resolve manufacturer drug rebate disputes are required to be corrected and resubmitted in compliance with APLs.

2.1.4 Network Provider Data Reporting

A. Contractor must maintain a MIS that collects and transmits Network Provider Data to DHCS in compliance with 42 CFR sections 438.207, 438.604(a)(5), and 438.606, and in accordance with APLs.

B. Contractor must implement policies and procedures for ensuring the complete, accurate, reasonable, and timely submission of Network Provider Data, Subcontractor data, and Downstream Subcontractor data to DHCS, as defined in State and federal law, APLs, DHCS 274 companion guide, and this Contract, that accurately represents Contractor's Network, whether directly or through Subcontractor Agreements, Downstream Subcontractor Agreements, or Network Provider Agreements.

C. Contractor must require all Network Providers, Subcontractors, and Downstream Subcontractors to submit Network Provider Data to Contractor to ensure compliance with this Contract. Contractor must have mechanisms, including edit and reporting systems, sufficient to ensure Network Provider Data is complete, accurate, reasonable, and timely, as defined in State and federal law and APLs, prior to submission to DHCS. Contractor must ensure the completeness, accuracy, reasonableness, and timeliness of all Network Provider, Subcontractor, and Downstream Subcontractor Network Provider Data regardless of contracting arrangements.

D. Contractor must submit complete, accurate, reasonable, and timely Network Provider Data within ten calendar days following the end of each month, or as mandated through federal law, and in a form and manner specified by DHCS. Contractor must certify all Network Provider Data as set forth in 42 CFR section 438.606. Subcontractors, Downstream

Subcontractors and Network Providers must comply with this Section for submission of Network Provider Data to Contractor.

E. DHCS will review and validate Contractor's Network Provider Data for completeness, accuracy, reasonableness, and timeliness.

F. If DHCS finds deficiencies regarding the completeness, accuracy, reasonableness, or timeliness of Contractor's Network Provider Data and notifies Contractor in writing of the deficiencies and requests correction and resubmission of the relevant Network Provider Data, Contractor must ensure that corrected Network Provider Data is resubmitted within 15 calendar days of the date of DHCS' notice, or as mandated through federal law. Upon Contractor's written request, DHCS may, in its sole discretion, grant an extension for submission of corrected Network Provider Data.

2.1.5 Program Data Reporting

A. Contractor must maintain a MIS that consumes and transmits Program Data to DHCS in compliance with Exhibit A, Attachment III, Article 7.0 (*Operations Deliverables and Requirements*) and in accordance with APLs.

B. Contractor must implement policies and procedures for ensuring the complete, accurate, reasonable, and timely submission of Program Data to DHCS, as defined in State and federal law, APLs, and this Contract, including, but not limited to, all Grievances, Appeals, referrals, out-of-Network requests, medical exemption request denial reports and other continuity of care requests, and Primary Care Provider (PCP) and Risk Tier assignments received or determined by Contractor, whether directly or through Subcontractor Agreements, Downstream Subcontractor Agreements, or Network Provider Agreements.

C. Contractor must require all Network Providers, Subcontractors, Downstream Subcontractors, and out-of-Network Providers to submit Program Data to Contractor to ensure compliance with this Contract. Contractor must have mechanisms, including edit and reporting systems, sufficient to ensure Program Data is complete, accurate, reasonable, and timely, as defined in State and federal law and APLs, prior to submission to DHCS. Contractor must ensure the completeness, accuracy, reasonableness, and timeliness of all Network Provider, Subcontractor, Downstream Subcontractor, and out-of-Network Provider Program Data regardless of contracting arrangements.

D. Contractor must submit complete, accurate, reasonable, and timely Program Data within ten calendar days following the end of each month,

or as mandated through federal law, and in a form and manner specified by DHCS. Contractor must certify all Program Data as set forth in 42 CFR section 438.606. Network Providers, Subcontractors, Downstream Subcontractors, and out-of-Network Providers must comply with this Subsection for submission of Program Data to Contractor.

E. DHCS will review and validate Contractor's Program Data for completeness, accuracy, reasonableness, and timeliness.

F. If DHCS finds deficiencies regarding the completeness, accuracy, reasonableness, or timeliness of Contractor's Program Data and notifies Contractor in writing of the deficiencies and requests correction and resubmission of the relevant Program Data, Contractor must ensure that corrected Program Data is resubmitted within 15 calendar days of the date of DHCS' notice, or as mandated through federal law. Upon Contractor's written request, DHCS may, in its sole discretion, grant an extension for submission of corrected Program Data.

2.1.6 Template Data Reporting

A. Contractor must maintain a MIS that collects and reports Template Data to DHCS in compliance with Exhibit A, Attachment III, Article 7.0 (*Operations Deliverables and Requirements*) and in accordance with APLs.

B. Contractor must implement policies and procedures for ensuring the complete, accurate, reasonable, and timely submission of Template Data to DHCS, as defined in State and federal law, APLs, and this Contract, for all items and services furnished to a Member under this Contract, whether directly or through Subcontractor Agreements, Downstream Subcontractor Agreements, or Network Provider Agreements.

C. Contractor must require all Network Providers, Subcontractors, and Downstream Subcontractors to submit Template Data to Contractor to ensure compliance with this Contract. Contractor must have mechanisms, including edit and reporting systems, sufficient to ensure Template Data is complete, accurate, reasonable, and timely, as defined in State and federal law and APLs, prior to submission to DHCS. Contractor must ensure the completeness, accuracy, reasonableness, and timeliness of all Network Provider, Subcontractor, and Downstream Subcontractor Template Data regardless of contracting arrangements.

D. Contractor must submit complete, accurate, reasonable, and timely Template Data on a regular basis, or as mandated through federal law, and in a form and manner specified by DHCS. Contractor must certify all Template Data as set forth in 42 CFR section 438.606. Subcontractors,

Downstream Subcontractors, and Network Providers must comply with this Subsection for submission of Template Data to Contractor.

E. DHCS will review and validate Contractor's Template Data for completeness, accuracy, reasonableness, and timeliness.

F. If DHCS finds deficiencies regarding the completeness, accuracy, reasonableness, or timeliness of Contractor's Template Data and notifies Contractor in writing of the deficiencies and requests correction and resubmission of the relevant Template Data, Contractor must ensure that corrected Template Data is resubmitted within 15 calendar days of the date of DHCS' notice, or as mandated through federal law. Upon Contractor's written request, DHCS may, in its sole discretion, grant an extension for submission of corrected Template Data.

2.1.7 Management Information System/Data Audits

Contractor must conduct MIS and data audits to the extent directed by DHCS, in accordance with this Contract, APLs, or other similar instructions which will be no less frequently than once every three years.

2.1.8 Management Information System/Data Correspondence

When DHCS provides Contractor with written notice of any problems or deficiencies related to the submittal of data to DHCS, or of any changes or clarifications related to Contractor's MIS system, Contractor must submit to DHCS a Corrective Action plan with measurable benchmarks within 15 calendar days from the date of DHCS' written notice to Contractor. DHCS will approve Contractor's Corrective Action plan or request revisions within 30 calendar days of receipt of Contractor's Corrective Action plan. If DHCS requests revisions, Contractor must submit a revised Corrective Action plan for DHCS' approval within 15 calendar days after receipt of the request. Contractor's failure to complete the Corrective Action plan as approved by DHCS will subject it to sanctions, pursuant to Exhibit E, Section 1.19 (*Sanctions*). DHCS may publicly disclose on the DHCS website any Contractors that have entered into Corrective Action plans or have been subject to sanctions due to non-compliance under this Section.

2.1.9 Tracking and Submitting Alternative Format Selections

A. Contractor must have and maintain systems that are able to, at a minimum, collect and store Member Alternative Format Selection (AFS), as well as the AFS of a Member's AR as specified in APL 25-016.

B. Contractor must utilize the 834 enrollment data file for the AFS process and provide Member materials in the requested alternative formats in

accordance with APL 25-016.

C. Contractor should direct Members to make or update their AFS in BenefitsCal or CoveredCA or with their local county office, in accordance with APL 25-016.

D. Contractor must submit to DHCS policies and procedures for collecting and sharing AFS data in accordance with the requirements in APL 25-016.

2.1.10 Interoperability Application Programming Interface System Requirements

A. In order to ensure Contractor applies the same standards for Encounter Data contained in Exhibit A, Attachment III, Section 2.1.2 (*Encounter Data Reporting*), to data collected and made available through its API, Contractor must verify that data collected from Network Providers, Subcontractors, and Downstream Subcontractors to be made available through the API is complete, accurate, reasonable, and timely, and collected in accordance with the oversight and monitoring requirements in APL 22-026. Contractor must make all collected data available to DHCS and CMS, upon request.

B. Contractor must conduct routine testing and monitoring of its API functions, and applying system updates as appropriate, to ensure that the API is compliant and functional.

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

Exhibit A, ATTACHMENT III

2.2 Quality Improvement and Health Equity Transformation Program

2.2.1 Quality Improvement and Health Equity Transformation Program Overview
2.2.2 Governing Board
2.2.3 Quality Improvement and Health Equity Committee
2.2.4 Provider Participation
2.2.5 Subcontractor and Downstream Subcontractor Quality Improvement Activities
2.2.6 Quality Improvement and Health Equity Transformation Program Policies and Procedures
2.2.7 Quality Improvement and Health Equity Annual Plan
2.2.8 National Committee for Quality Assurance Accreditation
2.2.9 External Quality Review Requirements
2.2.10 Quality Care for Children
2.2.11 Skilled Nursing Facilities—Long-Term Care
2.2.12 Disease Surveillance
2.2.13 Credentialing and Recredentialing

2.2 Quality Improvement and Health Equity Transformation Program

Contractor must implement a Quality Improvement and Health Equity Transformation Program (QIHETP) that includes, at a minimum, the standards set forth in 42 Code of Federal Regulations (CFR) sections 438.330 and 438.340, and 28 California Code of Regulations (CCR) section 1300.70, and be consistent with the principles outlined in the DHCS Comprehensive Quality Strategy and a forthcoming All Plan Letter (APL). Contractor must monitor, evaluate, and take timely action to address necessary improvements in the Quality of Care delivered by all its Providers in any setting, and take appropriate action to improve upon Health Equity. Contractor is responsible for the quality and Health Equity of all Covered Services regardless of whether or not those services have been delegated to a Subcontractor, Downstream Subcontractor, or Network Provider.

A. Contractor must deliver quality care that enables all its Members to maintain health and improve or manage a chronic illness or disability. Contractor must ensure quality care in each of the following areas:

   1) Clinical quality of physical health care;

   2) Clinical quality of Behavioral Health care focusing on prevention, recovery, resiliency, and rehabilitation;

   3) Access to primary and specialty health care Providers and services;

   4) Availability and regular engagement with Primary Care Providers (PCP);

   5) Continuity of care and Care Coordination across settings and at all levels of care, including transitions in care, with the goal of establishing consistent Provider-patient relationships; and

   6) Member experience with respect to clinical quality, access and availability, culturally and linguistically competent health care and services, continuity of care, and Care Coordination.

B. Contractor must apply the principles of continuous quality improvement (CQI) to all aspects of Contractor's service delivery system through analysis, evaluation, and systematic enhancements of the following:

   1) Quantitative and qualitative data collection and data-driven decision-making;

   2) Up-to-date evidence-based practice guidelines and explicit criteria developed by recognized sources or appropriately certified

professionals or, where evidence-based practice guidelines do not exist, consensus of professionals in the field;

3) Feedback provided by Members, community partners, and Network Providers in the design, planning, and implementation of its CQI activities; and

4) Other issues identified by Contractor or DHCS.

C. Contractor must develop Population Health Management interventions designed to address Social Drivers of Health (SDOH), reduce disparities in health outcomes experienced by different subpopulations of Members, and work towards achieving Health Equity by:

1) Developing equity-focused interventions intended to address disparities in the utilization and outcomes of physical and Behavioral Health care services; and

2) Engaging in a Member and family-centric approach in the development of interventions and strategies, and in the delivery of all health care services.

D. Contractor must ensure that the QIHETP requirements of this Contract are applied to the delivery of both physical and Behavioral Health Services.

2.2.1 Quality Improvement and Health Equity Transformation Program Overview

Contractor must maintain a QIHETP which includes the following, at a minimum:

A. Oversight and participation of Contractor's Governing Board;

B. Creation and designation of a Quality Improvement and Health Equity Committee (QIHEC) whose activities are supervised by Contractor's medical director or the medical director's designee, in collaboration with Contractor's Chief Health Equity Officer;

C. Supervision of QIHETP activities by Contractor's medical director and the Chief Health Equity Officer; and

D. The participation of a broad range of Network Providers, including but not limited to hospitals, clinics, county partners, physicians, Community Health Workers (CHWs), and other non-clinical Providers in the process of QIHETP development and performance review.

2.2.2 Governing Board

Contractor must implement and maintain written policies and procedures that specify the responsibilities of its Governing Board, which include the following, at a minimum:

A. Approving the overall QIHETP and the annual plan of the QIHETP;

B. Appointing an accountable entity or entities within Contractor's organization responsible for the oversight of the QIHETP;

C. Receiving written QIHEC progress reports that describe actions taken, progress in meeting QIHETP objectives, and improvements made; and

D. Directing necessary modifications to QIHETP policies and procedures to ensure compliance with the Quality Improvement (QI) and Health Equity standards in this Contract and the DHCS Comprehensive Quality Strategy.

2.2.3 Quality Improvement and Health Equity Committee

A. Contractor must implement and maintain a Quality Improvement and Health Equity Committee (QIHEC) designated and overseen by its Governing Board. Contractor's medical director or the medical director's designee must head QIHEC in collaboration with Contractor's Chief Health Equity Officer. Contractor must ensure that a broad range of Network Providers, including but not limited to hospitals, clinics, county partners, physicians, Subcontractors, Downstream Subcontractors, Network Providers, and Members, actively participate in the QIHEC or in any sub-committee that reports to the QIHEC. The Subcontractors, Downstream Subcontractors, and Network Providers that are part of QIHEC must be representative of the composition of Contractor's Network and include, at a minimum, Network Providers who provide health care services to Members affected by Health Disparities, Limited English Proficiency (LEP) Members, Children and Youth with Special Health Care Needs (CYSHCN), Seniors and Persons with Disabilities (SPDs), and persons with chronic conditions.

The QIHEC's responsibilities include the following:

1) Analyze and evaluate the results of QI and Health Equity activities including annual review of the results of performance measures, utilization data, consumer satisfaction surveys, and the findings and activities of other Contractor committees such as the Community Advisory Committee (CAC);

2) Institute actions to address performance deficiencies, including policy recommendations; and

3) Ensure appropriate follow-up of identified performance deficiencies.

B. Contractor must ensure Member confidentiality is maintained in QI discussions and ensure avoidance of conflict of interest among the QIHEC members.

C. Contractor must ensure that the QIHEC meets at least quarterly, and more frequently if needed. A written summary of QIHEC activities, as well as QIHEC activities of its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors, findings, recommendations, and actions must be prepared after each meeting and submitted to Contractor's Governing Board. Contractor must also submit the written summary to DHCS quarterly.

D. Contractor must make the written summary of the QIHEC activities publicly available on Contractor's website at least on a quarterly basis.

E. Contractor must ensure that its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors maintain a QIHEC that meets the requirements set forth in this Section. Contractor must also ensure that they report to Contractor's QIHEC quarterly, at a minimum.

2.2.4 Provider Participation

Contractor must ensure that its Network Providers, Fully Delegated Subcontractors, and Downstream Fully Delegated Subcontractors participate in the QIHETP and Population Needs Assessment (PNA) as described in Exhibit A, Attachment III, Subsection 4.3.2 (*Population Needs Assessment*). Contractor must incorporate its Fully Delegated Subcontractor and Downstream Fully Delegated Subcontractor data and results into the development of its PNA, as described in Exhibit A, Attachment III, Subsection 4.3.2 (*Population Needs Assessment*). Contractor must regularly update its Network Providers, Fully Delegated Subcontractors, and Downstream Fully Delegated Subcontractors on activities, findings, and recommendations of the QIHEC's QIHETP and PNA results.

2.2.5 Subcontractor and Downstream Subcontractor Quality Improvement Activities

A. Contractor is accountable for all QI and Health Equity functions and responsibilities that are delegated to Subcontractors and any Downstream Subcontractors, in accordance with Exhibit A, Attachment III, Subsection 3.1.1 (*Overview of Contractor's Duties and Obligations*). Contractor must, at a minimum, specify the following requirements in its Subcontractor Agreements and Downstream Subcontractor Agreements, as applicable:

1) QI or Health Equity responsibilities, and specific subcontracted functions and activities of Subcontractor and Downstream Subcontractor;

2) The schedule for Contractor's ongoing oversight, monitoring, and evaluation of Subcontractor and Downstream Subcontractor, including quarterly reporting and an annual review of Subcontractor's and Downstream Subcontractor's performance;

3) Subcontractor's and Downstream Subcontractor's reporting requirements and Contractor's approval procedure of Subcontractor's and Downstream Subcontractor's reports;

4) Subcontractor's and Downstream Subcontractor's obligation to report findings and actions of QI or Health Equity activities at least quarterly to Contractor; and

5) Contractor's actions and remedies if Subcontractor's and Downstream Subcontractor's obligations are not satisfactorily performed.

B. Contractor must maintain an adequate oversight procedure to ensure Subcontractor's and Downstream Subcontractor's compliance with all QI or Health Equity delegated activities that, at a minimum:

1) Evaluates Subcontractor's and Downstream Subcontractor's ability to perform the delegated activities, including an initial determination that Subcontractor and Downstream Subcontractor have the administrative capacity, experience, and budgetary resources to fulfill their contractual obligations;

2) Ensures Subcontractor and Downstream Subcontractor meet QI and Health Equity standards set forth in this Contract; and

3) Includes Contractor's continuous monitoring, evaluation and approval of its delegated functions to Subcontractor and Downstream Subcontractor. Contractor must make the findings of its continuous monitoring and evaluation of the Subcontractor and Downstream Subcontractor available to DHCS at least annually, but more frequently when directed by DHCS.

2.2.6 Quality Improvement and Health Equity Transformation Program Policies and Procedures

Contractor must develop, implement, maintain, and periodically update its QIHETP policies and procedures that include, at a minimum, the following:

A. Contractor's commitment to the delivery of quality and equitable health care services;

B. Contractor's, Fully Delegated Subcontractor's, and Downstream Fully Delegated Subcontractor's organizational chart, listing the key staff and the committees responsible for QI and Health Equity activities, including reporting relationships of QIHEC to executive staff;

C. Qualification and identification of staff who are responsible for QI and Health Equity activities;

D. A process for sharing QIHETP findings with its Subcontractors, Downstream Subcontractors, and Network Providers;

E. The role, structure, and function of the QIHEC;

F. The policies and procedures to ensure that all Covered Services are available and accessible to all Members regardless of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, health status, genetic information, marital status, gender, gender identity, or sexual orientation, or identification with any other persons or groups defined in Penal Code section 422.56, and that all Covered Services are provided in a culturally and linguistically appropriate manner;

G. The policies and procedures designed to identify, evaluate, and reduce Health Disparities, by performing the following:

    1) Analyzing data to identify differences in Quality of Care and utilization, as well as the underlying reasons for variations in the provision of care to its Members;

    2) Developing equity-focused interventions to address the underlying factors of identified Health Disparities, including SDOH; and

    3) Meeting disparity reduction targets for specific populations and/or measures as identified by DHCS and as directed under Exhibit A, Attachment III, Subsection 2.2.9.A (*Quality Performance Measures*).

H. Description of the integration of Utilization Management (UM) activities into the QIHETP as specified in Exhibit A, Attachment III, Section 2.3 (*Utilization Management Program*), including a process to integrate

reports on the number and types of service requests, denials, deferrals, modifications, Appeals, and Grievances to the medical director or the medical director's designee;

I. Policies and procedures to adopt, disseminate, and monitor the use of clinical practice guidelines that:

1) Are based on valid and reliable clinical evidence or a consensus of health care professionals in the relevant field;

2) Consider the needs of Members;

3) Stem from recognized organizations that develop or promulgate evidence-based clinical practice guidelines, or are developed with involvement of board-certified Providers from appropriate specialties;

4) Have been reviewed by Contractor's medical director, as well as Subcontractors, Downstream Subcontractors, and Network Providers, as appropriate; and

5) Are reviewed and updated at least every two years;

J. The inclusion of Population Health Management (PHM) activities, including the findings of the annual PNA, as required in Exhibit A, Attachment III, Subsection 4.3.2 (*Population Needs Assessment*);

K. Policies and procedures that ensure the delivery of Medically Necessary Non-Specialty Mental Health Services (NSMHS) and Specialty Mental Health Services (SMHS) as outlined in Exhibit A, Attachment III, Section 5.5 (*Mental Health and Substance Use Disorder Benefits*);

L. Policies and procedures that ensure that Contractor and its Subcontractors, Downstream Subcontractors, Network Providers, and other entities with which Contractor contracts for the delivery of health care services comply with all mental health parity requirements in 42 CFR section 438.900 *et seq*.;

M. Mechanisms to detect both over- and under-utilization of services including, but not limited to, outpatient Prescription Drugs;

N. Mechanisms to continuously monitor, review, evaluate, and improve access to and availability of all Covered Services. The mechanisms must include oversight processes that ensure Members are able to obtain Medically Necessary appointments within established standards for time or distance, timely access, and alternative access in accordance with APL

23-001, and Welfare and Institutions Code (W&I) sections 14197 and 14197.04;

O. Mechanisms to continuously monitor, review, evaluate, and improve quality and Health Equity of clinical care services provided, including, but not limited to, preventive services for Children and adults, perinatal care, Primary Care, specialty, emergency, inpatient, Behavioral Health and ancillary care services; and

P. Mechanisms to continuously monitor, review, evaluate, and improve coordination and continuity of care services to all Members, including SPDs, CYSHCNs, Members with chronic conditions, including Behavioral Health, Members experiencing homelessness, Members recently released from incarceration, Members who use Long-Term Services & Supports (LTSS), and Children receiving Child welfare services.

2.2.7 Quality Improvement and Health Equity Annual Plan

Through regional quality and health equity teams, Contractor must develop and submit an annual QI and Health Equity plan to DHCS, as directed below and in and a forthcoming APL.

A. Develop QI and Health Equity plan annually for submission to DHCS that includes the following, at a minimum:

1) A comprehensive assessment of the QI and Health Equity activities undertaken, including an evaluation of the effectiveness of QI interventions;

2) A written analysis of required Quality Performance Measure results, and a plan of action to address performance deficiencies, including analyses of each Fully Delegated Subcontractor's and Downstream Fully Delegated Subcontractor's performance measure results and actions to address any deficiencies;

3) An analysis of actions taken to address any Contractor-specific recommendations in the annual External Quality Review (EQR) technical report and Contractor's specific evaluation reports;

4) An analysis of the delivery of services and Quality of Care of Contractor and its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors, based on data from multiple sources, including quality performance results, Encounter Data, Grievances and Appeals, Utilization Review and the results of consumer satisfaction surveys;

5) Planned equity-focused interventions to address identified patterns of over- or under-utilization of physical and Behavioral Health care services;

6) A description of Contractor's commitment to Member and/or family focused care through Member and community engagement such as review of CAC findings, Member listening sessions, focus groups or surveys, and collaboration with local community organizations; and how Contractor utilizes the information from this engagement to inform Contractor policies and decision-making;

7) PHM activities and findings as outlined in Exhibit A, Attachment III, Section 4.3 (*Population Health Management and Coordination of Care*); and

8) Outcomes/findings from Performance Improvement Projects (PIPs), consumer satisfaction surveys and collaborative initiatives.

To the extent that Contractor delegates its QI and Health Equity activities to its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors, Contractor's QI and Health Equity annual plan must include evaluation and findings specific to the Fully Delegated Subcontractor's and Downstream Fully Delegated Subcontractor's performance.

B. Provide annual copies of all final reports of independent private accrediting agencies (e.g. the National Committee for Quality Assurance (NCQA)) relevant to Contractor's, Fully Delegated Subcontractor's, and Downstream Fully Delegated Subcontractor's Medi-Cal line of business, including:

1) Accreditation status, survey type, and level, as applicable;

2) Accreditation agency results, including recommended actions or improvements, Corrective Action plans, and summaries of findings; and

3) Expiration date of the accreditation.

In addition, pursuant to 42 CFR section 438.332, Contractor must authorize independent private accrediting agencies to provide DHCS a copy of Contractor's most recent accreditation review annually.

C. Provide an annual report to DHCS that includes an assessment of all Subcontractors' and Downstream Subcontractors' performance of its delegated QI or Health Equity activities.

D. Contractor must make the QI and Health Equity plan publicly available on its website on an annual basis.

E. Contractor must attend regional collaborative meetings which may include additional regional partners including but not limited to county Mental Health Plans (MHPs), Drug Medi-Cal (DMC), Drug Medi-Cal Organized Delivery System (DMC-ODS), Local Government Agencies, public hospitals, and community-based organizations (CBOs).

2.2.8 National Committee for Quality Assurance Accreditation

Contractor must have full NCQA Health Plan Accreditation (HPA) and NCQA Health Equity Accreditation by no later than January 1, 2026. Contractor must maintain full NCQA HPA and Health Equity Accreditation throughout the term of this Contract and submit every 3 years NCQA Health Plan Accreditation and Health Equity Accreditation results. Contractor must also complete additional NCQA accreditation programs as directed by DHCS.

In accordance with W&I section 14184.203, Contractor must also ensure that all its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors have full NCQA HPA and Health Equity Accreditation by no later than January 1, 2026. Contractor must also ensure all its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors maintain full NCQA HPA and Health Equity Accreditation throughout the term of this Contract. Contractor must ensure that its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors also complete additional NCQA accreditation programs as directed by DHCS.

Contractor must provide DHCS with the following components of Contractor's, Fully Delegated Subcontractor's, and Downstream Fully Delegated Subcontractor's NCQA HPA and Health Equity Accreditation status and reviews within 30 calendar days of the receipt of the completed report from NCQA:

A. Accreditation status;

B. Survey type;

C. Results of the review;

D. Healthcare Effectiveness Data and Information Set (HEDIS ®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS ®) summary level data;

E. Recommended actions or improvements;

F. Corrective Action plans and summaries of findings; and

G. Expiration date of the accreditation.

Contractor must notify DHCS of the date of its NCQA site visit within 15 calendar days of confirmation of the site visit by NCQA. Contractor must make available all written materials submitted to NCQA available to DHCS and allow DHCS representative(s) to participate in the NCQA audit activities, including but not limited to, the NCQA site visit.

Contractor must notify DHCS of any change in NCQA HPA and Health Equity Accreditation status within 30 calendar days of receipt of the final NCQA report. In addition to complying with the Corrective Actions imposed by NCQA, Contractor must also comply with any additional Corrective Actions imposed by DHCS to address a change in Contractor's accreditation status.

If Contractor fails to obtain or maintain its HPA or Health Equity Accreditation status within the timeframe described above and anytime thereafter, Contractor will be subject to Corrective Actions by DHCS, including but not limited to, the actions set forth in Exhibit E, Sections 1.16 (*Termination*), 1.19 (*Sanctions*), and 1.20 (*Liquidated Damages*).

Contractor must have policies and procedures in place to oversee the HPA and Health Equity Accreditation status of its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors throughout the term of this Contract. Contractor must have policies and procedures in place to subject its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors to Corrective Actions if Contractor's Fully Delegated Subcontractor or Downstream Fully Delegated Subcontractor fails to maintain its HPA and Health Equity Accreditation status, including, but not limited to, termination of Subcontractor Agreements or Downstream Subcontractor Agreements with Fully Delegated Subcontractors or Downstream Fully Delegated Subcontractors, sanctions, and damages.

2.2.9 External Quality Review Requirements

At least annually or more frequently as directed by DHCS, Contractor must cooperate with and assist the External Quality Review Organization (EQRO) designated by DHCS in conducting its EQR reviews of Contractor in accordance with 42 USC section 1396u-2(c)(2), 42 CFR section 438.310 *et seq.*, and 22 CCR section 53860(d).

Contractor must comply with all requirements set forth in 42 CFR section 438.310 *et seq*., the forthcoming APL, and the Centers for Medicare & Medicaid Services (CMS) EQR protocols, which provide detailed instructions on how to complete the EQR activities.

In addition, Contractor must also comply with the following requirements:

A. Quality Performance Measures

On an annual basis, Contractor must track and report on a set of Quality Performance Measures and Health Equity measures identified by DHCS in accordance with all of the following requirements:

1) Contractor must work with the EQRO to conduct an onsite assessment of the Quality Measure Compliance Audit and DHCS-required Quality Performance Measures;

2) Contractor must calculate and report all required Quality Performance Measures and Health Equity measures at the county or regional reporting unit level and possibly Skilled Nursing Facility (SNF) level as directed by DHCS. Contractor must separately report to DHCS all required performance measure results at the county or reporting unit level and SNF level for certain measures for its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors

   a) Contractor must calculate performance measure rates, to be verified by the EQRO;

   b) Contractor must report audited results on the required performance measures to DHCS no later than June 15 of each year or on another date as established by DHCS. Contractor must initiate reporting on required Quality Performance Measures for the reporting cycle following the first year of this Contract operation;

3) Contractor must meet or exceed the DHCS-established Minimum Performance Level (MPL) for each required Quality Performance Measure and Health Equity measure selected by DHCS. Contractor must ensure that its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors whose rates Contractor separately reports to DHCS also meet or exceed the DHCS-established MPL for each required Quality Performance Measure and Health Equity measure selected by DHCS.

4) Contractor must meet Health Disparity reduction targets for specific populations and measures as identified by DHCS.

5) In accordance with 42 CFR section 438.700 *et seq.*, W&I section 14197.7, and Exhibit E, DHCS may impose financial sanctions, administrative sanctions, and/or Corrective Actions on Contractor

for failure to meet or exceed required MPLs as detailed in APL 25-007. DHCS may require Contractor to make changes to its executive personnel if a Contractor has persistent and pervasive poor performance as evidenced by multiple performance measures consistently below the MPL over multiple years. DHCS may also limit Contractor's Service Area expansion or suspend Member Enrollment based on Contractor's persistent and pervasive poor performance on Quality Performance Measures.

In addition to sanctions and Corrective Actions, DHCS reserves the right, subject to actuarial judgment and generally accepted actuarial principles and practices, to consider Contractor's performance on specified quality and equity benchmarks, as determined by DHCS and communicated to Contractors in advance of each applicable Rating Period, within the determination of Capitation Payment rates for that Rating Period.

Contractor is responsible for ensuring that its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors also meet or exceed the DHCS-established MPL. If its Fully Delegated Subcontractor or Downstream Fully Delegated Subcontractor fails to meet or exceed the DHCS-established MPL, Contractor must have policies and procedures in place to subject its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors to appropriate enforcement actions, which may include, but are not limited to, financial sanctions, corrective action plans, and a requirement to change its executive personnel.

B. PIPs

1) Contractor must conduct or participate in PIPs, including any PIP required by CMS, in accordance with 42 CFR section 438.330. Contractor must conduct or participate in, at a minimum, two (2) PIPs per year, as directed by DHCS. At its sole discretion, DHCS may require Contractor to conduct or participate in additional PIPs, including statewide PIPs. DHCS may also require Contractor to participate in statewide collaborative PIP workgroups.

2) Contractor must have policies and procedures in place to ensure that its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors also conduct and participate in PIPs and any collaborative PIP workgroups as directed by CMS or DHCS.

3) Contractor must comply with the PIP requirements outlined in a forthcoming APL and must use the PIP reporting format as designated therein to request DHCS' approval of proposed PIPs.

4) Each PIP must include the following:

a) Measurement of performance using objective quality indicators;

b) Implementation of equity-focused interventions to achieve improvement in the access to and Quality of Care;

c) Evaluation of the effectiveness of the interventions based on the performance measures; and

d) Planning and initiation of activities for increasing or sustaining improvement.

5) Contractor must report the status of each PIP at least annually to DHCS.

C. Consumer Satisfaction Survey

1) On an annual basis until January 1, 2026, Contractor must timely provide all data requested by the EQRO in a format designated by the EQRO in conducting a consumer satisfaction survey.

2) Beginning January 1, 2026, concurrent with the requirement for HPA by the NCQA, Contractor must publicly post the annual results of its, and its Fully Delegated Subcontractor's and Downstream Fully Delegated Subcontractor's, CAHPS survey on Contractor's website, including results of any supplemental questions as directed by DHCS.

3) If Contractor has HPA prior to January 1, 2026, and reports its CAHPS data to the NCQA, Contractor must publicly post the annual results of its, and its Fully Delegated Subcontractor's and Downstream Fully Delegated Subcontractor's, CAHPS survey on Contractor's website, including results of any supplemental questions as directed by DHCS.

4) Contractor must incorporate results from the CAHPS survey in the design of QI and Health Equity activities.

D. Network Adequacy Validation

Contractor must participate in the EQRO's validation of Contractor's Network adequacy representations from the preceding 12 months to comply with requirements set forth in 42 CFR sections 438.14(b), 438.68, and 438.358.

E. Encounter Data Validation

As directed by DHCS, Contractor must participate in EQRO's validation of Encounter Data from the preceding 12 months to comply with requirements set forth in 42 CFR sections 438.242(d) and 438.818.

F. Focused Studies

As directed by DHCS, Contractor must participate in an external review of focused clinical and/or non-clinical topic(s) as part of DHCS' review of quality outcomes and timeliness of, and access to, services provided by Contractor.

G. Technical Assistance

In accordance with 42 CFR section 438.358(d) and at the direction of DHCS, Contractor must implement EQRO's technical guidance provided to Contractor in conducting mandatory and optional activities described in 42 CFR section 438.358 and this Contract.

2.2.10 Quality Care for Children

Contractor must maintain a robust program to ensure the provision of all physical, behavioral, and oral health services to Members less than 21 years of age. Contractor must also maintain mechanisms to identify and improve on gaps in the quality of and access to care in each of the following areas:

A. Scope of Services

1) Contractor must ensure the provision of all screening, preventive and Medically Necessary diagnostic and treatment services for Members less than 21 years of age in accordance with Exhibit A, Attachment III, Subsection 5.3.4 (*Services for Members Less Than 21 Years of Age*);

2) Contractor must actively promote Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screenings and American Academy of Pediatrics (AAP) Bright Futures preventive services to Members and their families. Per APL 23-005, on an annual basis by January 1 of each year, Contractor must mail or share electronically, DHCS Medi-Cal for Kids and Teens Materials for existing Members under the age of 21. For new Members, Contractor is required to mail or share electronically, DHCS Medi-Cal for Kids and Teens Materials within seven calendar days of the enrollment. Additionally, Contractor must ensure Network Providers

receive standardized training on EPSDT utilizing the developed DHCS Medi-Cal for Kids and Teens Outreach and Education Toolkit;

3) Contractor must identify Members who have not utilized EPSDT screening services or AAP Bright Futures preventive services and ensure outreach to these Members in a culturally and linguistically appropriate manner;

4) Contractor must maintain Memorandums of Understanding (MOUs) with Local Health Departments (LHDs) and Local Government Agencies (LGAs), in Contractor's Service Area(s), including but not limited to California Children's Services (CCS), the Women, Infants and Children Supplemental Nutrition Program (WIC), maternal and Child health, social services, Regional Centers, and Child welfare departments, as outlined in Exhibit A, Attachment III, Subsection 5.6.1 (*MOU Purpose*) in order to facilitate the provision of EPSDT services to Members less than 21 years of age;

5) Contractor must comply with APL 23-005 requirements to include conducting ongoing training, at least once every two years, for Network Providers on required preventive healthcare services, including EPSDT services for Members less than 21 years of age as outlined in Exhibit A, Attachment III, Subsection 3.2.5.B (*Network Provider Training*), to ensure Providers are able to support Members and families in fully utilizing EPSDT services.

B. Utilization Management

Contractor must ensure that all requirements outlined in Exhibit A, Attachment III, Section 2.3 (*Utilization Management Program*) apply to the review and provision of Medically Necessary services for Members less than 21 years of age.

C. Population Health Management (PHM) and Coordination of Care

1) Contractor must ensure that all requirements outlined in Exhibit A, Attachment III, Section 4.3 (*Population Health Management and Coordination of Care*), including the development of the annual PNA, apply to Members less than 21 years of age;

2) Contractor and its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors must provide a comprehensive wellness and prevention program to all Members less than 21 years of age, which includes but is not limited to (see full requirements in Exhibit A, Attachment III, Subsection 4.3.8 (*Basic Population Health*

Management)) initiatives, programs, and evidence-based approaches to improving access to preventive health visits, developmental screenings, and services for Members less than 21 years of age, as described in Exhibit A, Attachment III, Subsection 5.3.4 (*Services for Members Less Than 21 Years of Age*).

D. Network and Access to Care

1) Contractor must ensure that each Member less than 21 years of age has an assigned PCP as well as access to Specialists for Covered Services and Medically Necessary services, in accordance with Exhibit A, Attachment III, Subsection 5.2.1 (*Access to Network Providers and Covered Services*);

2) Contractor must provide information to all Network Providers regarding the Vaccines for Children (VFC) Program and is expected to promote and support Enrollment of applicable Network Providers in the VFC program in order to improve access to immunizations; and

3) Contractor must maintain and continually monitor, improve, and evaluate cultural and linguistic services that support the delivery of Covered Services to Members less than 21 years of age, in accordance with Exhibit A, Attachment III, Subsection 5.2.11 (*Cultural and Linguistic Programs and Committees*).

E. Quality and Health Equity

1) Contractor must identify and address underutilization of Children's preventive services including but not limited to EPSDT services such as well Child visits, developmental screenings and immunizations;

2) Contractor must report on DHCS-identified Quality Performance Measures and Health Equity performance measures related to health care services for Members less than 21 years of age, and must exceed any DHCS-specified MPL, in accordance with Exhibit A, Attachment III, Subsection 2.2.9.A (*Quality Performance Measures*);

3) Contractor must engage with local entities when developing interventions and strategies to address deficiencies in performance measures related to health care services for Members less than 21 years of age;

4) Contractor must meet any Health Disparity reduction targets for specific populations and measures for Members less than 21 years of age, as identified by DHCS and in accordance with Exhibit A, Attachment III, Subsection 2.2.9.A.2 (*Quality Performance Measures*);

5) Contractor must participate in any value-based payment programs for services provided to Members less than 21 years of age, as directed by DHCS;

6) Contractor must engage in planned Health Equity-focused interventions to address identified gaps in the quality of and access to care for Members less than 21 years of age, including preventive and screening services; and

7) Contractor must engage in a Member and family-oriented engagement strategy to QI and Health Equity, including Children and caregiver representation on the Community Advisory Committee (CAC), and using CAC findings and recommendations, and the results of Member listening sessions, focus groups and surveys, to inform QI and Health Equity interventions, as outlined in Exhibit A, Attachment III, Subsection 5.2.11.D. (*Cultural and Linguistic Programs and Committees*).

F. Mental Health and Substance Use Disorder Services

Contractor must adhere to all requirements of Exhibit A, Attachment III, Section 5.5 (*Mental Health and Substance Use Disorder Benefits*) for the provision of mental health and Substance Use Disorder services to Members less than 21 years of age, as appropriate, including collaborating with county Behavioral Health plans and complying with APL 23-010 and all mental health parity requirements in 42 CFR section 438.900 *et seq*.

Contractor must collaborate with DHCS in its effort to implement the California Children and Youth Behavioral Health Initiative.

G. School-Based Services

By January 1, 2026, or a later date as determined by DHCS, to facilitate the provision of Medically Necessary services to Children, Contractor must collaborate, negotiate in good faith, and execute MOUs with Local Education Agencies (LEAs) and/or County Offices of Education, as applicable, if agreed to by all stakeholders involved, in each county within Contractor's Service Area for school-based services. School-based services include but are not limited to EPSDT and Behavioral Health

Services for Members less than 21 years of age. Contractor must also ensure that Members' Primary Care Providers (PCPs) cooperate and collaborate with LEAs in the development of Individualized Education Plans (IEPs) or Individualized Family Service Plans (IFSPs) and ultimately ensure that care is coordinated regardless of financial responsibility, as outlined in Exhibit A, Attachment III, Subsections 4.3.16 (*School-Based Services*) and 5.6.1 (*MOU Purpose*).

2.2.11 Skilled Nursing Facilities – Long-Term Care

Contractor must implement and maintain policies and procedures for providing applicable Long-Term Care (LTC) services for Members as detailed in Exhibit A Attachment III, Subsection 5.3.7.G *(Services for All Members).* Contractors must maintain a comprehensive Quality Assurance Performance Improvement (QAPI) program for LTC services provided. Contractors must have a system in place to collect quality assurance and improvement findings from CDPH to include, but not be limited to, survey deficiency results, site visit findings, and complaint findings. Contractor's comprehensive QAPI program must incorporate all requirements in APL 23-004.

2.2.12 Disease Surveillance

Contractor must implement and maintain procedures for reporting any serious diseases or conditions to both local and State public health authorities and to implement directives from the public health authorities as required by law, including but not limited to, 17 CCR section 2500 *et seq*.

2.2.13 Credentialing and Recredentialing

Contractor and its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors must implement and maintain written policies and procedures regarding the initial Credentialing, recredentialing, recertification, and reappointment of Network Providers in accordance with 42 CFR section 438.214 and APL 22-013. Contractor and its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors must ensure its policies and procedures are reviewed and approved by its Governing Board. Contractor must ensure that the responsibility for recommendations regarding Credentialing decisions rests with a Credentialing committee or other peer review body.

A. Standards

Contractor and its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors must ensure that all their Network Providers who deliver Covered Services and have executed Network Provider Agreements with Contractor are qualified in accordance with current

applicable legal, professional, and technical standards, and are appropriately licensed, certified, or registered.

Contractor and its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors must ensure that all their Network Providers have good standing in the Medicare and Medicaid/Medi-Cal programs and have a valid National Provider Identifier (NPI) number. Contractor must ensure that Providers that have been terminated from either Medicare or Medicaid/Medi-Cal cannot participate in Contractor's Network.

Contractor and its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors must ensure that all contracted Laboratory Testing Sites have either a Clinical Laboratory Improvement Act (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number.

B. Subcontractor and Downstream Subcontractor Credentialing

Contractor may delegate Credentialing and recredentialing activities, but Contractor remains ultimately responsible for the completeness and accuracy of these activities, as outlined in Exhibit A, Attachment III, Subsection 3.1.1 (*Overview of Contractor's Duties and Obligations*).

C. Credentialing Provider Organization Certification
Contractor may obtain Credentialing provider organization certification (POC) from the NCQA. Contractor may accept evidence of NCQA POC certification in lieu of a monitoring visit at Network Provider's facilities.

D. Disciplinary Actions

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

E. Medi-Cal and Medicare Provider Status

Contractor must verify that its Subcontractors, Downstream Subcontractors, and Network Providers have not been terminated as Medi-Cal or Medicare Providers or have not been placed under a restriction (payment or temporary suspension) resulting in placement on the Suspended and Ineligible Provider List, List of Excluded Entities, or Restricted Provider Database. Contractor cannot maintain contracts with

Network Providers, Subcontractors, or Downstream Subcontractors who have been terminated by either Medicare or Medi-Cal or placed on the Suspended and Ineligible Provider List.

F. Contractor's NCQA Health Plan Accreditation

If Contractor has received an accredited status from NCQA, Contractor will be deemed to meet the DHCS requirements for Credentialing and may be exempt from the DHCS medical review audit for Credentialing.

G. Credentialing of Other Non-Physician Providers

Contractor and its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors must develop and maintain policies and procedures that ensure that the credentials of Nurse Practitioners, Certified Nurse Midwives (CNMs), clinical nurse Specialists, Physician Assistants, mental health Providers, and substance use treatment Providers have been verified in accordance with State requirements applicable to the Provider category.

Exhibit A, ATTACHMENT III

2.3 Utilization Management Program

2.3.1 Prior Authorizations and Review Procedures
2.3.2 Timeframes for Medical Authorization
2.3.3 Review of Utilization Data
2.3.4 Delegating Utilization Management Activities

2.3 Utilization Management Program

Contractor must develop, implement, update as needed (but at least annually), and improve its Utilization Management (UM) program to ensure appropriate processes are used to review and approve the provision of Medically Necessary Covered Services for its Members. Contractor must ensure that its UM program:

A. Includes a designated medical director or clinical director responsible for the UM process in accordance with Health & Safety Code (H&S) section 1367.01, and qualified staff responsible for the UM program.

B. Prohibits medical decisions to be influenced by fiscal and administrative management. Compensation of individuals or entities that conduct UM activities must not be structured to provide incentives to deny, limit, or discontinue Medically Necessary Covered Services.

C. Allows for a second opinion from a qualified health professional within the Network, if available. If a qualified health professional within the Network is not available, Contractor must authorize an out-of-Network Provider to provide the second opinion at no cost to the Member, in accordance with 42 Code of Federal Regulations (CFR) section 438.206.

D. Makes available to Network Providers all relevant UM policies and procedures upon request.

E. Makes available to Members all relevant UM policies and procedures upon request. Makes available to Members clinical criteria used by Contractor, Subcontractors, and Downstream Subcontractors, as applicable for assessing Medical Necessity for Covered Services.

F. Provides training to Network Providers on the procedures and services that require Prior Authorization for Medically Necessary Covered Services, and ensures that all Network Providers are aware of the procedures and timeframes necessary to obtain Prior Authorization for Medically Necessary Covered Services, within 30 calendar days of executing this Contract and within 30 calendar days of contracting with a Network Provider.

G. Has a Standing Referral process providing a determination within three Working Days from the date the request is made by the Member or the Member’s Primary Care Providers (PCP) and all appropriate Medical Records and other items of information necessary to make the determination are provided. Once a determination is made, the referral must be made within four Working Days of the date that the proposed treatment plan, if any, is submitted to Contractor’s medical director or the medical director’s designee, in accordance with H&S section 1374.16.

H. Has a specialty referral system to track and monitor referrals requiring Prior Authorization by Contractor. When Prior Authorization is delegated to Subcontractors and Downstream Subcontractors, Contractor must ensure that Subcontractors and Downstream Subcontractors have systems in place to track and monitor referrals requiring Prior Authorization and must furnish documentation of Subcontractor's and Downstream Subcontractor's referrals to DHCS upon request. Contractor's specialty referral systems must include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals. Contractor's specialty referral systems must include information on requested out-of-Network services. Contractor must ensure that all Network Providers are aware of the specialty referral processes and tracking procedures.

I. Integrates UM activities into the Quality Improvement System (QIS) specified in Exhibit A, Attachment III, Section 2.2 (*Quality Improvement and Health Equity Transformation Program*), including a process to integrate reports on the number and types of service requests, denials, deferrals, modifications, Appeals, and Grievances to the medical director or their designee.

J. Has timelines and processes that do not impose Quantitative Treatment Limitations (QTL) or Non-Quantitative Treatment Limitations (NQTL) more stringently on covered mental health and Substance Use Disorder (SUD) services than are imposed on medical/surgical services, in accordance with the parity in mental health and SUD requirements in 42 CFR section 438.900, et seq.

K. Makes Contractor's UM policies and procedures available to Members and Providers on Contractor's website and upon request. These policies and procedures must set out how Contractor authorizes, modifies, delays, or denies health care services via Prior Authorization, concurrent authorization, or Retrospective Review, under the services provided by Contractor in accordance with 42 CFR section 438.915.

1) Contractor must ensure that policies and procedures for authorization decisions are based on the Medical Necessity of a requested Covered Service and are consistent with criteria or guidelines supported by sound clinical principles and evidence-based practice.

2) Contractor must ensure that policies, processes, strategies, evidentiary standards, and other factors used for UM are consistently applied to medical/surgical, mental health, and SUD services and benefits.

3) Contractor must notify Network Providers, as well as Members and Potential Members upon request, of all services that require Prior Authorization, concurrent authorization, or Retrospective Review, and ensure that all Network Providers are aware of the procedures and timeframes necessary to obtain authorization for these services.

L. Contractor must ensure that any use of artificial intelligence decision-making tools in the review of Provider requests for Prior Authorization, concurrent review, or Retrospective Review of health care services is supervised by a licensed physician or other qualified health care professional. If Contractor uses an artificial intelligence, algorithm, or other software tool for utilization review or management based in whole or in part on Medical Necessity, Contractor must ensure that it complies with H&S Section 1367.01(k).

All UM activities must be performed in accordance with H&S sections 1363.5 and 1367.01 and 28 California Code of Regulations (CCR) section 1300.70(a)(3), (b)(2)(H), and (c).

2.3.1 Prior Authorizations and Review Procedures

Contractor must ensure that its Prior Authorization, concurrent review, and Retrospective Review authorization procedures meet the following minimum requirements, in accordance with H&S section 1367.01:

A. Contractor must consult with Providers as needed for Prior Authorization requests for the purposes of determining Medical Necessity for Covered Services unless doing so would lead to undue delay in care;

B. Decisions to deny or to authorize an amount, duration, or scope that is less than requested must be made by a qualified health care professional with appropriate clinical expertise in treating the medical or Behavioral Health condition and disease or Long-Term Services and Supports (LTSS) needs. Appropriate clinical expertise may be demonstrated by relevant specialty training, experience, or certification. Qualified health care professionals do not have to be an expert in all conditions and may use other resources to make appropriate decisions;

C. Qualified health care professionals must supervise the review of medical decisions, including service reductions, and must review all denials that are made, in whole or in part, based on Medical Necessity. Contractor is not responsible for the review of Prior Authorizations for physician administered drugs, medical supplies, enteral nutritional products, and covered outpatient Prescription Drugs provided by an outpatient pharmacy. Contractor must review Prior Authorizations for physician

administered drugs which include Prescription Drugs administered by a health care professional in a clinic, physician's office, or outpatient setting; medical supplies; and enteral nutritional products. These Prescription Drugs and supplies are covered under the medical benefit and would be included in the medical claim or encounter;

D. Contractor must establish written criteria or guidelines for UM that are developed with practicing health care Providers. The written criteria or guidelines must be based on sound clinical practices and processes which are evaluated and updated when necessary, and at least annually, in accordance with H&S section 1363.5;

E. Contractor must provide a clear and concise written explanation of the reasons for denying, deferring, or modifying a service; a description of the criteria or guidelines used; and the clinical reasons for the decision based on Medical Necessity. Any written communication to a Provider of a denial, delay, or modification of a request must include the name and telephone number of Contractor's health care professional responsible for the denial, delay, or modification;

F. Contractor must notify Members regarding denied, deferred or modified referrals as specified in Exhibit A, Attachment III, Subsection 5.1.5, (*Notices of Action for Denial, Deferral, or Modification of Prior Authorization Requests*). Contractor must publish on its website an Appeals procedure for both Providers and Members;

G. Decisions and Appeals must be made in a timely manner and not be unduly delayed when Member's medical condition requires time sensitive services;

H. Prior Authorization requirements must not be applied to Emergency Services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, Human Immunodeficiency Virus (HIV) testing, or initial mental health and SUD assessments;

I. Records relating to Prior Authorization requests, including any Notices of Action (NOA), must meet the retention requirements described in Exhibit E, Section 1.22 (*Inspection and Audit of Records and Facilities*);

J. Contractor must notify the requesting Provider of any decision to deny, approve, modify, or delay a service authorization request, a request by a Member or a Member's Provider for the provision of a Covered Service, or when authorizing a service in an amount, duration, or scope that is less than requested. The notice to the Provider may be oral or in writing;

K. All of Contractor's authorization requirements must comply with the requirements for parity in mental health and SUD benefits in 42 CFR section 438.900, et seq.

2.3.2 Timeframes for Medical Authorization

A. Emergency Services: Contractor must not require Prior Authorization for Emergency Services for complaints or conditions that a prudent layperson would determine could seriously jeopardize their physical or mental health.

B. Post-Stabilization Care Services: Contractor must respond to a Network Provider's or out-of-Network Provider's request for authorization for Post-Stabilization Care Services within 30 minutes or the service is deemed approved, in accordance with All Plan Letter (APL) 23-009.

C. Non-Urgent Care Following an Exam in the Emergency Room: Contractor must respond to a Provider's request for Post-Stabilization Care Services within 30 minutes or the service is deemed approved.

D. Retrospective Review Authorization Request for Treatment Received: Contractor must accept requests for Retrospective Review authorization within a reasonably established time limit, not to exceed 365 calendar days from the date of service. Contractor must communicate decisions to the Provider and to the Member who received the services or to the Member's Authorized Representative (AR) within 30 calendar days of the receipt of information that is reasonably necessary to make this determination, in accordance with 42 CFR section 438.404(a) and H&S section 1367.01(h)(1).

E. Routine Authorizations: Contractor must respond to routine requests and concurrent requests as expeditiously as the Member's condition requires, but no longer than five Working Days from receipt of the information reasonably necessary and requested by Contractor to render a decision, and no longer than 14 calendar days from Contractor's receipt of the request, in accordance with 42 CFR section 438.210 and H&S section 1367.01.

F. Expedited Authorizations: Contractor must make expedited authorization decisions for service requests where a Member's Provider indicates, or Contractor, Subcontractor, Downstream Subcontractor, or Network Provider determines that, following the standard timeframe for Prior Authorizations and concurrent requests could seriously jeopardize the Member's life; health; or ability to attain, maintain, or regain maximum function, in accordance with 42 CFR section 438.210 and H&S section 1367.01. Contractor must provide its authorization decision as expeditiously as the Member's health condition requires, but no longer

than 72 hours after Contractor's receipt of the request for services. All Contractors must also expedite Prior Authorization requests for Members who are transitioning from an acute care hospital to all settings including Contractor chosen Community Supports and for Members entering short-term post-hospitalization housing, recuperative care, or sobering centers as described in Exhibit A, Attachment III, Subsection 4.5.2 *(Optional Community Supports)* regardless of where they are transitioning from and make an authorization decision in a timeframe that is appropriate for the nature of the Member's condition but is no longer than 72 hours after Contractor's receipt of all information needed to make an authorization decision.

G. Hospice Services: Contractor must only require Prior Authorization for inpatient hospice care in accordance with 22 CCR section 51349 and APL 25-008. Contractor must respond to inpatient hospice care authorization requests in accordance with 22 CCR section 51003 and APLs.

H. Therapeutic Enteral Formula: Contractor must comply with all timeframes for medical authorization of Medically Necessary therapeutic enteral formula billed on a medical or institutional claim and the equipment and supplies necessary for delivery of enteral formula billed on a medical or institutional claim, as set forth in all applicable DHCS APLs, Welfare and Institutions Code (W&I) section 14103.6, and H&S section 1367.01.

I. Physician Administered Drugs: Contractor must respond to requests for medical authorization of Medically Necessary physician administered drugs billed on a medical or institutional claim within 24 hours of receipt of the request, in accordance with 42 USC section 1396r-8, 42 CFR sections 438.210 and 438.3, and W&I section 14185. If the physician administered drug is a "covered outpatient drug," as defined in 42 USC section 1396r-8(k)(2) and (k)(3), Contractor cannot obtain an extension of time to respond. However, if the physician administered drug is not a "covered outpatient drug," Contractor may obtain an extension of time to respond, as set forth in 42 CFR section 438.210.

2.3.3 Review of Utilization Data

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

B. Contractor must monitor utilization data to appropriately identify Members eligible for Enhanced Care Management (ECM) and applicable

Community Supports as specified in Exhibit A, Attachment III, Subsection 4.4.6 (*Member Identification for Enhanced Care Management)* and Subsection 4.5.7 (*Identifying Members for Community Supports)*.

C. Contractor must monitor and track Non-Specialty Mental Health Services (NSMHS) utilization data for Members. Upon request, Contractor must submit data to DHCS.

2.3.4 Delegating Utilization Management Activities

Contractor may delegate UM activities. If Contractor delegates any UM activities, Contractor must comply with Exhibit A, Attachment III, Subsection 2.2.5 (*Subcontractor and Downstream Subcontractor Quality Improvement Activities*).

Exhibit A, ATTACHMENT III

3.0 Providers, Network Providers, Subcontractors, and Downstream Subcontractors

DHCS is committed to ensuring that all Contractors are aware of their obligations under this Contract and are committed to being accountable not only for their own obligations, but for those of their Subcontractors and Downstream Subcontractors for delegated functions. In this Article, DHCS includes provisions requiring Contractors to disclose what entities provide delegated functions through Subcontractor Agreements and Downstream Subcontractor Agreements as applicable.

In addition, Contractors are to demonstrate that they have robust compliance, monitoring, and oversight programs, including for all delegated entities to ensure Members receive quality care and have access to services. This Article requires Contractors to not only disclose delegation arrangements but include justification for the use of delegated entities to ensure that the Member's experience and outcomes are front and center. DHCS is particularly focused on those entities that take risk; thus this Article includes provisions requiring reporting of Subcontractors and Downstream Subcontractors that assume responsibility for taking that risk and managing the health care of a portion of assigned lives.

This Article articulates DHCS' commitment in moving the delivery system towards value-based payment. Contractors are to report on the proportion of spend that is tied to value. In addition, Contractors are to implement Financial Arrangements that link payments to value in the form of higher quality of care, better health care outcomes, and lower cost of care. Such arrangements include, but are not limited to, incentive payment arrangements that reward Providers for high or improved performance on selected measures or benchmarks. Finally, Contractors are to report on the proportion of spend on Primary Care specifically in an effort to encourage investment in Primary Care as appropriate.

3.1 Network Provider Agreements, Subcontractor Agreements, Downstream Subcontractor Agreements, and Contractor's Oversight Duties

3.1.1 Overview of Contractor's Duties and Obligations
3.1.2 DHCS Approval of Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements
3.1.3 Contractor's Duty to Disclose All Delegated Relationships and to Submit Delegation Reporting and Compliance Plan
3.1.4 Contractor's Duty to Ensure Subcontractor, Downstream Subcontractor, and Network Provider Compliance
3.1.5 Requirements for Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements
3.1.6 Financial Viability of Subcontractors, Downstream Subcontractors, and Network Providers
3.1.7 Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements with Federally Qualified Health Centers and Rural Health Clinics
3.1.8 Network Provider Agreements with Safety-Net Providers
3.1.9 Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements with Local Health Departments
3.1.10 Nondiscrimination in Provider Contracts
3.1.11 Public Records
3.1.12 Requirement to Post

3.1 Network Provider Agreements, Subcontractor Agreements, Downstream Subcontractor Agreements, and Contractor's Oversight Duties

3.1.1 Overview of Contractor's Duties and Obligations

A. Contractor is fully responsible for all duties and obligations set forth in this Contract. However, Contractor may enter into agreements with other individuals, groups, or entities to fulfill its obligations and duties under the Contract, including Network Provider Agreements and Subcontractor Agreements. Some individuals, groups, or entities may be a combination of Network Provider, Subcontractor, and/or Downstream Subcontractor, in which case they would need to comply with the requirements for Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements, as applicable. Subcontractors and Downstream Subcontractors may enter into agreements to fulfill their obligations and duties under the Contract, in which case they would need to comply with the requirements of Downstream Subcontractor Agreements or Network Provider Agreements, as applicable.

B. Contractor must ensure that all Subcontractors and Downstream Subcontractors comply with all Contract requirements related to the delegated functions undertaken by each Subcontractor or Downstream Subcontractor. Contractor remains fully responsible for the performance of all duties and obligations it delegates to Subcontractors and Downstream Subcontractors. To ensure Subcontractor's and Downstream Subcontractor's compliance, Contractor must, at a minimum, do the following:

1) Include all Contract duties and obligations relating to the delegated duties in the Subcontractor Agreement;

2) Ensure Subcontractor includes all Contract obligations relating to the delegated duties in all Downstream Subcontractor Agreements;

3) Provide policies and procedures to Subcontractors applicable to the delegated functions and ensure Subcontractor provides the relevant policies and procedures as applicable to delegated functions;

   Monitor and oversee all delegated functions, including those that may flow down to Downstream Subcontractors; and

4) Provide to DHCS a delegation reporting and compliance plan, as set forth in Exhibit A, Attachment III, Subsection 3.1.3 (*Contractor's Duty to Disclose All Delegated Relationships and to Submit Delegation Reporting and Compliance Plan*).

C. Contractor must ensure that Network Providers comply with all applicable Contract requirements and all requirements set forth in their Network Provider Agreements (See Exhibit A, Attachment III, Subsection 3.1.5.A (*Network Provider Agreement Requirements).*

3.1.2 DHCS Approval of Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements

A. Submission and Approval of Network Provider Agreements Templates

1) Contractor must submit to DHCS all Network Provider Agreement templates, and any proposed amendments thereto, for review and approval before use. The contents of the Network Provider Agreement templates are set forth in All Plan Letter (APL) 19-001.

2) Within 60 calendar days of receipt, DHCS will make all reasonable efforts to approve in writing the use of all Network Provider Agreement templates. DHCS will provide Contractor with a written explanation indicating whether the template is approved, disapproved, or an estimated date for completion of DHCS' review. If DHCS does not complete its review of Network Provider Agreement templates within 60 calendar days of receipt, or within DHCS' estimated date of completion, whichever is later, Contractor may elect to implement or use the material at Contractor's sole risk and subject to possible subsequent disapproval by DHCS.

B. Submission and Approval of Subcontractor Agreements and Downstream Subcontractor Agreements Templates

1) Contractor must submit to DHCS all Subcontractor Agreement and Downstream Subcontractor Agreement templates, and any amendments thereto, as follows:

a) For Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors, Contractor must submit all Subcontractor Agreement and Downstream Subcontractor Agreement templates and any amendments thereto, to DHCS for review and approval before use. Contractor must also file with DHCS all executed Subcontractor Agreements with Fully Delegated Subcontractors and all executed Downstream Subcontractor Agreements with Downstream Fully Delegated Subcontractors.

b) For Partially Delegated Subcontractors and Administrative Subcontractors, and Downstream Partially Delegated

Subcontractors and Downstream Administrative Subcontractors, Contractor must submit all Subcontractor Agreements and Downstream Subcontractor Agreements templates, and any amendments thereto, to DHCS for review and approval prior to execution of the Subcontractor Agreement or Downstream Subcontractor Agreement.

2) Within 60 calendar days of receipt, DHCS will make all reasonable efforts to approve in writing the use of Subcontractor Agreement and Downstream Subcontractor Agreement templates submitted by Contractor. DHCS will provide Contractor with a written explanation indicating whether the template is approved, disapproved, or an estimated date for completion of DHCS review. If DHCS does not complete its review of the submitted material within 60 calendar days of receipt, or by DHCS estimated date of completion, whichever is later, Contractor may elect to implement or use the template at Contractor's sole risk and subject to possible subsequent disapproval by DHCS.

3.1.3 Contractor's Duty to Disclose All Delegated Relationships and to Submit Delegation Reporting and Compliance Plan

A. Content of Delegation Reporting and Compliance Plan

Contractor must report its delegation and compliance plan using the templates provided in Exhibit J *(Delegation Reporting and Compliance Plan),* which includes, but is not limited to, the following:

1) All Contractor's contractual relationships with Subcontractors and Downstream Subcontractors;

2) Contractor's oversight responsibilities for all delegated obligations; and

3) How Contractor intends to oversee all delegated activities, including, but not limited to, details regarding key personnel who will be overseeing each delegated function.

B. Timing of Submission

Contractor must submit its delegation reporting and compliance plan to DHCS as follows:

1) During the operational readiness period;

2) Annually, whether or not changes have been made to its delegation structure; and

3) Anytime there is a change in the delegation reporting and compliance plan, including but not limited to a change in a Subcontractor and/or a change in the scope of the delegation.

The report must be submitted within 30 calendar days from either the beginning of the annual reporting period or any change, as identified above.

3.1.4 Contractor's Duty to Ensure Subcontractor, Downstream Subcontractor, and Network Provider Compliance

Contractor must maintain policies and procedures approved by DHCS to ensure that Network Providers, Subcontractors, and Downstream Subcontractors fully comply with all applicable terms and conditions of this Contract and all duties delegated to Subcontractors and Downstream Subcontractors as set forth above. Contractor must evaluate each prospective Network Provider's, Subcontractor's, and Downstream Subcontractor's ability to perform the contracted services or functions, must oversee and remain responsible and accountable for any services or functions undertaken by a Network Provider, Subcontractor, or Downstream Subcontractor, and must meet all applicable requirements set forth in State and federal law, regulation, any APLs or DHCS guidance, and this Contract.

3.1.5 Requirements for Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements

A. Network Provider Agreement Requirements

Network Provider Agreements must contain the following provisions:

1) Specification of the Covered Services to be ordered, referred, or rendered in accordance with 22 CCR sections 53250(c)(1) and 53867;

2) The term of the agreement, including the beginning and ending dates as well as methods of extension, renegotiation, phaseout, and termination, if any in accordance with 22 CCR sections 53250(c)(4) and 53867;

3) Full disclosure of the method and amount of compensation or other consideration to be received by Network Provider in accordance with 22 CCR sections 53250(e)(2) and 53867;

4) Specification that the agreement will be governed by and construed in accordance with all applicable laws and regulations governing the Contract, including but not limited to, Knox-Keene Health Care Service Plan Act of 1975 (KKA), Health and Safety Code (H&S) section 1340 *et seq*. (unless excluded under this Contract); Welfare and Institutions Code (W&I) sections 14000 and 14200 *et seq.*; 28 California Code of Regulations (CCR) section 1300.43 *et seq.*; and 22 CCR sections 53800 *et seq.*, 22 CCR sections 53900 *et seq*; 22 CCR sections 53250(c)(2) and 53867;

5) Network Provider will comply with all applicable requirements of the DHCS Medi-Cal Managed Care Program, including but not limited to, all applicable federal and State Medicaid and Medi-Cal laws, regulations, sub-regulatory guidance, APLs, and provisions of this Contract;

6) Network Provider will submit to Contractor, either directly or through a Subcontractor or Downstream Subcontractor as applicable, complete, accurate, reasonable, and timely Encounter Data and Provider Data, and any other reports or data as requested by Contractor, in order for Contractor to meet its data reporting requirements to DHCS in accordance with DHCS guidance, including but not limited to APL 14-009, APL 16-019, and APL 20-017;

7) Network Provider will maintain and make available to DHCS, upon request, copies of all contracts it enters into related to ordering, referring, or rendering Covered Services under the Network Provider Agreement, and will ensure that all such contracts are in writing;

8) Network Provider must make all of its premises, facilities, equipment, books, records, contracts, and computer and other electronic systems pertaining to the Covered Services ordered, referred, or rendered under the terms of the Network Provider Agreement, available for the purpose of an audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in Exhibit E, Section 1.22 (*Inspection and Audit of Records and Facilities*) and 42 CFR section 438.3(h), as follows:

    a) In accordance with inspections and audits, as directed by DHCS, The Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services (DHHS) Inspector General, the Comptroller General,

Department of Justice (DOJ), the Department of Managed Health Care (DMHC), or their designees; and

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

9) Network Provider will maintain all books and records, including Encounter Data, in accordance with good business practices and generally accepted accounting principles for a term annual of at least ten years from the final date of the Contract period or from the date of completion of any audit, whichever is later;

10) Network Provider will timely gather, preserve and provide to DHCS, CMS, the Division of Medi-Cal Fraud and Elder Abuse (DMFEA), and any authorized State or federal regulatory agencies, any records in Network Provider's possession, in accordance with Exhibit E, Section 1.27 (*Litigation Support*);

11) Network Provider will assist Contractor, or if applicable a Subcontractor or Downstream Subcontractor, in the transfer of Member's care in accordance with Exhibit E, Section 1.17 (*Phaseout Requirements*) in the event of Contract termination, or in the event of termination of the Network Provider Agreement for any reason;

12) Network Provider will be terminated, or subject to other actions, fines, and/or penalties, if DHCS or Contractor determine that the Network Provider has not performed satisfactorily in accordance with 42 CFR section 438.230(c)(iii) and 22 CCR sections 53250 and 53867;

13) Network Provider will hold harmless both the State and Members in the event Contractor or, if applicable a Subcontractor or Downstream Subcontractor, cannot or will not pay for Covered Services ordered, referred, or rendered by Network Provider pursuant to the Network Provider Agreement in accordance with 22 CCR sections 53250(e)(6) and 53867;

14) Network Provider will not bill a Member for Medi-Cal Covered Services;

15) Contractor must inform Network Provider of prospective requirements added by State or federal law or DHCS related to this Contract that impact obligations undertaken through the Network Provider Agreement before the requirement would be effective, and

agreement by Network Provider to comply with the new requirements within 30 calendar days of the effective date, unless otherwise instructed by DHCS;

16) Network Provider must ensure that cultural competency/humility, sensitivity, Health Equity, and diversity training is provided for employees and staff at key points of contact with Members in accordance with Exhibit A, Attachment III, Subsection 5.2.11.C. (*Cultural and Linguistic Programs and Committees*);

17) Network Provider must provide interpreter services for Members and comply with language assistance standards developed pursuant to H&S section 1367.04;

18) Network Provider must notify Contractor, and Contractor's Subcontractor or Downstream Subcontractor, within ten Working Days of any suspected Fraud, Waste, or Abuse and a provision that allows Contractor to share such information with DHCS in accordance with Exhibit A, Attachment III, Subsection 1.3.2.D (*Contractor's Reporting Obligations*) and Subsection 1.3.2.D.6 (*Confidentiality*);

19) Network Provider must report to Contractor, or Contractor's Subcontractor or Downstream Subcontractor, when it has received an overpayment; return the overpayment to Contractor, or Contractor's Subcontractor or Downstream Subcontractor, within 60 calendar days of the date the overpayment was identified; and notify Contractor, or Contractor's Subcontractor or Downstream Subcontractor, in writing of the reason for the overpayment in accordance with Exhibit A, Attachment III, Subsection 1.3.6 (*Treatment of Overpayment Recoveries*) and 42 Code of Federal Regulations (CFR) section 438.608(d)(2);

20) Confirmation of Network Provider's right to all protections afforded them under the Health Care Providers' Bill of Rights, including, but not limited to Network Provider's right to access Contractor's dispute resolution mechanism and submit a Grievance pursuant to H&S section 1367(h)(1).

21) Network Provider must execute the California Health and Human Services Data Exchange Framework data sharing agreement pursuant to H&S section 130290.

22) Network Provider will comply with all applicable timely access requirements in H&S section 1367.03 and specify how Covered Services will be provided to ensure timely access.

23) Contractor will adhere to all required timeframes for the processing of Clean Claims, in compliance with Exhibit A, Attachment III, Subsection 3.3.5 (*Claims Processing*) and APL 23-020.

24) Inclusion of Contractor's Provider Dispute Resolution Mechanism process in accordance with Exhibit A, Attachment III, Subsection 3.2.2.B (*Provider Dispute Resolution Mechanism*).

25) In accordance with Exhibit A, Attachment III, Subsection 6.1.3.C.3 (*Member Emergency Preparedness Plan*), a Network Providers are required to:

    a) Annually submit evidence of adherence to CMS Emergency Preparedness Final Rule (FR), 81 FR 63859, and 84 FR 51732;

    b) Advise Contractor as part of the Network Provider's emergency plan; and

    c) Notify Contractor within 24 hours of an emergency if the Network Provider closes down, is unable to meet the demands of a medical surge, or is otherwise affected by an emergency.

26) In Network Provider Agreements with Long-Term Care (LTC) Providers, Contractor must have a clause stating that LTC Providers must notify Contractor if it is undergoing a change of ownership so that Contractor can obtain preapproval of assessment of suitability from the California Department of Public Health (CDPH) in accordance with Exhibit A, Attachment III, Subsection 5.2.3.J (*Network Composition*).

27) In Network Provider Agreements with Local Health Departments (LHDs), Contractor must specify the scope and responsibilities of both parties in the provision of services to Members, billing and reimbursements, reporting responsibilities, and how services are to be coordinated between the LHD and Contractor, including exchange of medical information as necessary in accordance with Exhibit A, Attachment III, Subsection 3.1.9.B (*Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements with Local Health Departments*).

28) Network Provider must not pay any amount for any services or items, other than Emergency Services, to an Excluded Provider as described in: Exhibit A, Attachment III, Subsection 1.3.4

(*Contractor's Obligations Regarding Suspended, Excluded, and Ineligible Providers*); Exhibit A, Attachment III, Subsection 3.3.18 (*Prohibition Against Payment to Excluded Providers*); 42 USC section 1396b(i)(2); and APL 21-003.

B. Subcontractor and Downstream Subcontractor Agreement Requirements

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

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

2) The term of the Subcontractor Agreement or Downstream Subcontractor Agreement, including the beginning and ending dates as well as methods of extension, renegotiation, phaseout, and termination, if any in accordance with 22 CCR sections 53250(c)(4) and 53867;

3) Full disclosure of the method and amount of compensation or other consideration to be received by Subcontractor or Downstream Subcontractor per unit of service in accordance with 22 CCR sections 53250(e)(2) and 53867;

4) Specification that the Subcontractor Agreement or Downstream Subcontractor Agreement and amendments will only become effective as set forth in this Exhibit A, Subsection 3.1.2 (*DHCS Approval of Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements*);

5) Subcontractor's assignment or delegation of an obligation or responsibility under a Subcontractor Agreement to any Downstream Subcontractor is void unless prior written approval is obtained from DHCS;

6) Downstream Subcontractor's assignment or delegation of an obligation or responsibility under a Downstream Subcontractor Agreement to any Downstream Subcontractor is void unless prior written approval is obtained from DHCS;

7) Specification that the Subcontractor Agreement or Downstream Subcontractor Agreement is governed by and construed in accordance with all applicable laws and regulations governing the

Contract, including but not limited to 42 CFR section 438.230; KKA, H&S section 1340 *et seq*. (unless otherwise excluded under this Contract); 28 CFR section 1300.43 *et seq.*; W&I sections 14000 and 14200 *et seq.*; and 22 CCR sections 53800 *et seq.*, 22 CCR sections 53900 *et seq*; and 22 CCR sections 53250(c)(2) and 53867;

8) Subcontractor and Downstream Subcontractors must comply with all applicable requirements of the DHCS Medi-Cal Managed Care Program, pertaining to the obligations and functions undertaken pursuant to the Subcontractor Agreement or Downstream Subcontractor Agreement, including but not limited to, all applicable federal and State Medicaid and Medi-Cal laws, regulations, sub-regulatory guidance, APLs, and the provisions of this Contract;

9) Language comparable to Exhibit A, Attachment III, Subsection 3.3.16 (*Emergency Services and Post-Stabilization Care Services*), for those Subcontractors or Downstream Subcontractors obligated to reimburse Providers of Emergency Services;

10) Subcontractor and Downstream Subcontractors must submit to Contractor, either directly or through a Subcontractor or Downstream Subcontractor as applicable, complete, accurate, reasonable, and timely Encounter Data and Provider Data, and any other reports and data as requested by Contractor, in order for Contractor to meet its reporting requirements to DHCS in accordance with DHCS guidance, including but not limited to APL 14-009, APL 16-019, and APL 20-017;

11) Subcontractor and Downstream Subcontractors must comply with all monitoring provisions of this Contract and any monitoring requests by DHCS;

12) Subcontractor and Downstream Subcontractors must maintain and make available to DHCS, upon request, copies of all contracts it enters into related to the performance of the obligations and functions it undertakes pursuant to the Subcontractor Agreement, and to ensure that such contracts are in writing;

13) Subcontractor and Downstream Subcontractors must make all of their premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the obligations and functions undertaken pursuant to the Subcontractor Agreement or Downstream Subcontractor Agreement, available for the purpose of an audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State’s Right

to Monitor, as set forth in Exhibit E, Section 1.22 (*Inspection and Audit of Records and Facilities*) and 42 CFR section 438.3(h), as follows:

a) In accordance with inspections and audits, as directed by DHCS, CMS, U.S. DHHS Inspector General, the Comptroller General, DOJ, DMHC, or their designees; and

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

14) Subcontractor and Downstream Subcontractors must maintain all of its books and records, including Encounter Data, in accordance with good business practices and generally accepted accounting principles for a term of at least ten years from the final date of the Contract period or from the date of completion of any audit, whichever is later;

15) Subcontractor and Downstream Subcontractors must timely gather, preserve, and provide to DHCS, CMS, DMFEA, and any authorized State or federal regulatory agencies, any records in Subcontractor's possession, in accordance with Exhibit E, Section 1.27 (*Litigation Support*).

16) Subcontractor and Downstream Subcontractors must assist Contractor as applicable in the transfer of the Member's care as needed, and in accordance with Exhibit E, Section 1.17 (*Phaseout Requirements*), in the event of Contract termination, or in the event of termination of the Subcontractor Agreement or Downstream Subcontractor Agreement for any reason;

17) Subcontractor and Downstream Subcontractors must notify Subcontractor and/or Contractor, as applicable, in the event the Subcontractor Agreement or any Downstream Subcontractor Agreement is amended or terminated;

18) Subcontractor and Downstream Subcontractors will be terminated, or subject to other actions, fines, and/or penalties, if DHCS or Contractor determines that the Subcontractor and Downstream Subcontractor has not performed satisfactorily in accordance with 42 CFR section 438.230(c)(iii) and 22 CCR sections 53250 and 53867;

19) Subcontractor and Downstream Subcontractors must hold harmless both the State and Members in the event Contractor, or

another Subcontractor or Downstream Subcontractor as applicable, cannot or will not pay for the obligations and functions undertaken pursuant to the Subcontractor Agreement or Downstream Subcontractor Agreement;

20) Subcontractor and Downstream Subcontractors must participate and cooperate in Contractor's Quality Improvement System as applicable;

21) If Subcontractor or Downstream Subcontractors takes on Quality Improvement activities, the Subcontractor Agreement or Downstream Subcontractor Agreement must include those provisions stipulated in Exhibit A, Attachment III, Subsection 2.2.5 (*Subcontractor and Downstream Subcontractor Quality Improvement Activities*);

22) To the extent Subcontractor or Downstream Subcontractor undertakes coordination of care obligations and functions for Members, an agreement to share with Subcontractor and Downstream Subcontractor any utilization data that DHCS has provided to Contractor, and agreement by the Subcontractor and Downstream Subcontractors to receive the utilization data provided and use it solely for the purpose of Member Care Coordination;

23) Contractor must inform Subcontractor of prospective requirements added by federal or State law or DHCS related to this Contract that impact obligations and functions undertaken pursuant to the Subcontractor Agreement before the requirement is effective, and Subcontractor's agreement to comply with the new requirements within 30 calendar days of the effective date, unless otherwise instructed by DHCS;

24) Subcontractor or Downstream Subcontractors must inform the Downstream Subcontractor taking on delegated functions of prospective requirements added by federal or State law or DHCS related to this Contract that impact obligations and functions undertaken pursuant to the Downstream Subcontractor Agreement before the requirement is effective, and the agreement of the Downstream Subcontractor taking on delegated functions to comply with the new requirements within 30 calendar days of the effective date, unless otherwise instructed by DHCS;

25) Subcontractor and Downstream Subcontractors must ensure that cultural competency/humility, sensitivity, Health Equity, and diversity training is provided for Subcontractor's and Downstream Subcontractor's staff at key points of contact with Members in

accordance with Exhibit A, Attachment III, Subsection 5.2.11.C. (*Cultural and Linguistic Programs and Committees*);

26) Subcontractor and Downstream Subcontractors must provide interpreter services for Members and comply with language assistance standards developed pursuant to H&S section 1367.04;

27) Subcontractor and Downstream Subcontractors must notify Contractor within ten Working Days of any suspected Fraud, Waste, or Abuse and a provision that allows Contractor to share such information with DHCS in accordance with Exhibit A, Attachment III, Subsection 1.3.2.D (*Contractor's Reporting Obligations*) and Subsection 1.3.2.D.6) (*Confidentiality*);

28) Subcontractor and Downstream Subcontractors must report directly to Contractor, or through the Subcontractor or Downstream Subcontractor, as applicable, when it has received an overpayment; return the overpayment to Contractor within 60 calendar days after the date the overpayment was identified; and notify Contractor in writing of the reason for the overpayment in accordance with Exhibit A, Attachment III, Subsection 1.3.6 *(Treatment of Overpayment Recoveries) and* 42 CFR section 438.608(d)(2);

29) Subcontractor and Downstream Subcontractors must perform the obligations and functions of Contractor undertaken pursuant to the Subcontractor Agreement or Downstream Subcontractor Agreement, including but not limited to reporting responsibilities, in compliance with Contractor's obligations under this Contract in accordance with 42 CFR section 438.230(c)(1)(ii); and

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

31) Subcontractors and Downstream Subcontractors must execute the California Health and Human Services Data Exchange Framework data sharing agreement, if applicable, pursuant to H&S section 130290.

32) Specification of Subcontractors', including Downstream Subcontractors', MLR reporting and remittance obligations pursuant to 42 CFR sections 438.8 and 438.230(c) and Paragraph 11 of the 1915(b) CalAIM Special Terms and Conditions (STCs), which include, but are not limited to, the requirements in:

a) Exhibit A, Attachment III, Subsection 1.2.5.A.2 (*Medical Loss Ratio*) for the CalAIM 1915(b) STC downstream requirements and four-part test;

b) Exhibit A, Attachment III, Subsection 1.2.5.B (*Medical Loss Ratio*) for the MLR Experience Defined;

c) Exhibit A, Attachment III, Subsections 1.2.5. C and D (*Medical Loss Ratio*) for the Materiality Threshold;

d) Exhibit A, Attachment III, Subsection 1.2.5. E (*Medical Loss Ratio*) for the MLR numerator and incurred claims for Subcontractors and Downstream Subcontractors;

e) Exhibit A, Attachment III, Subsection 1.2.5.E.1.e.iii (*Medical Loss Ratio*) for remittances paid by Subcontractors and Downstream Subcontractors must be excluded from incurred claims;

f) Exhibit A, Attachment III, Subsection 1.2.5.F (*Medical Loss Ratio*) for MLR denominator;

g) Exhibit A, Attachment III, Subsection 1.2.5.G (*Medical Loss Ratio*) for Subcontractor and Downstream Subcontractor allocation of expenses;

h) Exhibit A, Attachment III, Subsection 1.2.5.H (*Medical Loss Ratio*) for Subcontractor and Downstream Subcontractor credibility adjustments;

i) Exhibit A, Attachment III, Subsection 1.2.5.I (*Medical Loss Ratio*) for materiality threshold;

j) Exhibit A, Attachment III, Subsection 1.2.5.J (*Medical Loss Ratio*) for Subcontractor and Downstream Subcontractor MLR reporting at Subcontractor or Downstream Subcontractor arrangement level by county or rating region;

k) Exhibit A, Attachment III, Subsection 1.2.5.K (*Medical Loss Ratio*) for general MLR reporting requirement imposed on Subcontractors and Downstream Subcontractors;

l) Exhibit A, Attachment III, Subsection 1.2.5.K.4 (*Medical Loss Ratio*) for Subcontractor and Downstream Subcontractor reporting requirements on downstream entities that accept financial risk;

m) Exhibit A, Attachment III, Subsection 1.2.5.K.5 (*Medical Loss Ratio*) for Subcontractor and Downstream Subcontractor MLR submission accuracy attestation;

n) Exhibit A, Attachment III, Subsection 1.2.5.K.6 (*Medical Loss Ratio*) for requirements for Subcontractor and Downstream MLR submissions and oversight requirements;

o) Exhibit A, Attachment III, Subsection 1.2.5.M (*Medical Loss Ratio*) for newer experience exemptions for Subcontractors and Downstream Subcontractors;

p) Exhibit A, Attachment III, Subsection 1.2.5.O (*Medical Loss Ratio*) for Subcontractor and Downstream Subcontractor re-reporting requirements following a retroactive change to the Capitation Payments for a MLR reporting year;

q) Exhibit A, Attachment III, Subsection 1.2.5.P (*Medical Loss Ratio*) for Subcontractor and Downstream Subcontractor remittance requirements; and

r) Exhibit A, Attachment III, Subsection 1.2.5.Q (*Medical Loss Ratio*) for Subcontractor and Downstream Subcontractor audit and record retention requirements.

33) Subcontractor and Downstream Subcontractors will comply with all applicable timely access requirements in H&S section 1367.03 and provide specification of how Covered Services will be provided to ensure timely access.

34) Subcontractor and Downstream Subcontractors will adhere to all required timeframes for the processing of Clean Claims, in compliance with Exhibit A, Attachment III, Subsection 3.3.5 (*Claims Processing*) and APL 23-020.

35) Inclusion of Subcontractor and Downstream Subcontractors' Provider Dispute Resolution Mechanism process in the

Subcontractor and Downstream Subcontractor Agreement in accordance with Exhibit A, Attachment III, Subsection 3.2.2.B (*Provider Dispute Resolution Mechanism*).

36) In accordance with Exhibit A, Attachment III, Subsection 6.1.3.C.3 (*Member Emergency Preparedness Plan),* Subcontractor and Downstream Subcontractors are required to:

a) Annually submit evidence of adherence to CMS Emergency Preparedness Final Rule (FR), 81 FR 63859, and 84 FR 51732;

b) Advise Contractor as part of Subcontractor and Downstream Subcontractors' emergency plan; and

c) Notify Contractor within 24 hours of an emergency if Subcontractor and Downstream Subcontractors close down, is unable to meet the demands of a medical surge, or is otherwise affected by an emergency;

37) In Network Provider Agreements with LTC Providers, Contractor must have a clause stating that LTC Providers and/or any Subcontractor contracted with the LTC Network Provider must notify Contractor if it is undergoing a change of ownership so that Contractor can obtain preapproval of assessment of suitability from CDPH in accordance with Exhibit A, Attachment III, Subsection 5.2.3.J (*Network Composition*).

38) In Subcontractor and Downstream Subcontractor Agreements with LHDs, Subcontractor and Downstream Subcontractors must specify the scope and responsibilities of both parties in the provision of services to Members, billing and reimbursements, reporting responsibilities, and how services are to be coordinated between the LHD and Subcontractor and Downstream Subcontractors, including exchange of medical information as necessary in accordance with Exhibit A, Attachment III, Subsection 3.1.9.B (*Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements with Local Health Departments*).

3.1.6 Financial Viability of Subcontractors, Downstream Subcontractors, and Network Providers

Contractor must maintain a system to evaluate and monitor the financial viability of all Network Providers, Subcontractors, and Downstream Subcontractors that accept financial risk for the provision of Covered Services including, but not

limited to, Medi-Cal managed care plans, independent Physician/Provider associations, medical groups, hospitals, risk-bearing organizations as defined by 28 CCR section 1300.75.4(b), Federal Qualified Health Centers (FQHC), and other clinics.

3.1.7 Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements with Federally Qualified Health Centers and Rural Health Clinics

Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements with FQHCs, Rural Health Clinics (RHCs), and other clinics must meet the requirements of Exhibit A, Attachment III, Subsections 3.1.5.A and B (*Network Provider Agreement Requirements* and *Subcontractor and Downstream Subcontractor Agreement Requirements*), above, and the reimbursement requirements set forth in Exhibit A, Attachment III, Subsection 3.3.7 (*Federally Qualified Health Center, Rural Health Center, and Indian Health Care Provider)*. Network Provider Agreements, Subcontractor Agreements, or Downstream Subcontractor Agreements with FQHCs, RHCs, and other clinics also must contain a provision stating that any negotiated and agreed-upon rate with an FQHC, RHC, or other clinic constitutes complete reimbursement and payment in full for the Covered Services rendered to a Member.

3.1.8 Network Provider Agreements with Safety-Net Providers

Except as provided in subdivisions (A), (B), or (C), Contractor must offer a Network Provider Agreement to, and maintain a Network Provider Agreement with, any Safety-Net Provider physically located and operating within Contractor's contracted geographic service areas if the Safety-Net Provider agrees to provide its applicable scope of services under the same terms and conditions that Contractor requires of other similar Providers.

A. If a Safety-Net Provider is no longer willing to accept a Network Provider Agreement on the same terms and conditions required of other similar Providers, and Contractor elects to terminate or not renew the Network Provider Agreement as a result, Contractor must notify DHCS of its intent to terminate or not renew that Network Provider Agreement with the applicable Safety-Net Provider at least 60 calendar days prior to the effective date of the intended Network Provider Agreement termination or non-renewal.

B. If Contractor determines that the Safety-Net Provider has engaged in Fraud, Waste, or Abuse of the Medi-Cal program; that there are quality of care concerns relating to the Safety-Net Provider's services; or that the Safety-Net Provider has materially breached its Network Provider Agreement, and Contractor elects to terminate or not renew the Network Provider Agreement as a result, Contractor must notify DHCS of its intent

to terminate or not renew that Network Provider Agreement with the applicable Safety-Net Provider at least 60 calendar days prior to the effective date of the intended Network Provider Agreement termination or non-renewal.

C. If DHCS or Contractor determines that the health or welfare of a Medi-Cal Member is threatened by the Provider, Contractor may terminate or not renew the Network Provider Agreement with the applicable Safety-Net Provider immediately, but Contractor must notify DHCS and the Safety-Net Provider of the termination or non-renewal concurrently.

D. If the license of the Safety-Net Provider is revoked or suspended, Contractor must terminate the Network Provider Agreement with the applicable Safety-Net Provider immediately upon discovery of such revocation or suspension, but Contractor must notify DHCS and the Safety-Net Provider of the termination concurrently.

3.1.9 Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements with Local Health Departments

A. Contractor must negotiate in good faith and execute Network Provider Agreements and Subcontractor Agreements, as appropriate, with the Local Health Department (LHD) in each county within Contractor's Service Area for the following public health services:

1) Family Planning Services, as specified in Exhibit A, Attachment III, Subsection 3.3.9 (*Non-Contracting Family Planning Providers*);

2) Sexually Transmitted Disease (STD) services, as specified in Exhibit A, Attachment III, Subsection 3.3.10 (*Sexually Transmitted Disease*), including diagnosis and treatment of the following: syphilis, gonorrhea, chlamydia, herpes simplex, chancroid, trichomoniasis, human papilloma virus, non-gonococcal urethritis, lymphogranuloma venereum, and granuloma inguinal;

3) Human Immunodeficiency Virus (HIV) testing and counseling as specified in Exhibit A, Attachment III, Subsection 3.3.11 (*Human Immunodeficiency Virus Testing and Counseling*); and

4) Immunizations as specified in Exhibit A, Attachment III, Subsection 3.3.12 (*Immunizations*).

B. Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements with LHDs must specify the scope and responsibilities of both parties in the provision of services to Members, billing and reimbursements, reporting responsibilities, and how

services are to be coordinated between the LHD and Contractor, including exchange of medical information as necessary. Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements must also meet the requirements described in Exhibit A, Attachment III, Subsection 3.1.5 (*Requirements for Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements*).

3.1.10 Nondiscrimination in Provider Contracts

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

3.1.11 Public Records

To the extent DHCS receives Contractor's Network Provider Agreements, Subcontractor Agreements, or Downstream Subcontractor Agreements, these agreements and all information received in accordance with these agreements will be public records on file with DHCS, except as specifically exempted in statute. The names of the officers and owners of the Network Provider, Subcontractor or Downstream Subcontractor; stockholders owning more than 5 percent of the stock issued by the Network Provider, Subcontractor or Downstream Subcontractor; and major creditors holding more than 5 percent of the debt of the Network Provider, Subcontractor, or Downstream Subcontractor must be attached to the Network Provider Agreement, Subcontractor Agreement, or Downstream Subcontractor Agreement at the time that agreement is submitted to DHCS.

3.1.12 Requirement to Post

Contractor must post on its website a summary of its delegation model that outlines how it delegates obligations and duties of this Contract to Fully

Delegated Subcontractors, Partially Delegated Subcontractors, Downstream Fully Delegated Subcontractors, and Downstream Partially Delegated Subcontractors.

Exhibit A, ATTACHMENT III

3.2 Provider Relations

3.2.1 Exclusivity
3.2.2 Provider Dispute Resolution Mechanism
3.2.3 Out-of-Network Provider Relations
3.2.4 Contractor's Provider Manual
3.2.5 Network Provider Training
3.2.6 Emergency Department Protocols
3.2.7 Prohibited Punitive Action Against the Provider
3.2.8 Submittal of Inpatient Days Information

3.2 Provider Relations

3.2.1 Exclusivity

Contractor must not, by use of any exclusivity provision, clause, agreement, nor in any other way, prohibit any Network Provider from providing services to other persons enrolled in Medi-Cal who are not Contractor's Members.

3.2.2 Provider Dispute Resolution Mechanism

In accordance with Health and Safety Code (H&S) section 1367(h)(1), Contractor must have a fast, fair, and cost-effective Provider Dispute Resolution Mechanism in place for Network Providers and out-of-Network Providers to submit disputes.

A. Contractor must have a formal procedure to accept, acknowledge, and resolve Network Provider and out-of-Network Provider disputes. The Provider Dispute Resolution Mechanism must occur in accordance with the timeframes set forth in H&S sections 1371 and 1371.35 for both Network Providers and out-of-Network Providers. Any Provider of Medi-Cal services may submit a dispute to Contractor regarding:

   1) The authorization or denial of a service;

   2) The processing of a payment or non-payment of a claim by Contractor; or

   3) The timeliness of the reimbursement on an uncontested Clean Claim and any interest Contractor is required to pay on claims reimbursement per APL-23-020.

B. Contractor's Provider Dispute Resolution Mechanism must be set forth in all Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements.

C. Contractor must inform all Network Providers, out-of-Network Providers, Subcontractors, and Downstream Subcontractors of its Provider Dispute Resolution Mechanism, regardless of contracting status.

D. Contractor must resolve Network Provider and out-of-Network Provider disputes within the timeframes set forth in H&S section 1371.35 of receipt of the dispute, including supporting documentation.

E. Contractor must submit a Provider Dispute Resolution Mechanism report annually to DHCS which includes information on the number of Providers who utilized the Provider Dispute Resolution Mechanism and a summary of the disposition of those disputes, in accordance with H&S section

1367(h)(3). This report must be delineated by Network Providers and out-of-Network Providers, and by Contractor, Subcontractor, or Downstream Subcontractor.

F. On an annual basis, Contractor must assess the Network Providers and out-of-Network Providers that utilize the Provider Dispute Resolution Mechanism to identify trends and systemic issues. Contractor must submit the results of its annual assessment to DHCS with discussion on how it is addressing trends and systemic issues identified based on the assessment.

3.2.3 Out-of-Network Provider Relations

A. Contractor must develop and maintain protocols for payment of claims to out-of-Network Providers, and for communicating and interacting with out-of-Network Providers regarding services and claims payment.

B. Contractor must provide its clinical protocols and evidence-based practice guidelines governing Prior Authorization, Utilization Management (UM) and Retrospective Review to all out-of-Network Providers providing services to its Members. Contractor must arrange to provide these protocols and guidelines at the time that Contractor enters into an agreement with an out-of-Network Provider or anytime an out-of-Network Provider submits a claim for services provided to Contractor's Members.

3.2.4 Contractor's Provider Manual

Contractor must issue a Provider manual to Network Providers, Subcontractors, and Downstream Subcontractors that includes information regarding Medi-Cal Covered Services and responsibilities for the provision of services including Basic Population Health Management (Basic PHM); Care Coordination for Excluded Services; policies and procedures; quality assurance; improvement and monitoring; clinical protocols governing Prior Authorization and UM; timeliness standards; Credentialing; prohibited claims; statutes; regulations; telephone access; special requirements; data reporting; and the Member Grievance, Appeal, and State Hearing process. Contractor must ensure the most updated Provider manual is available through Provider portals, the internet, or upon request. When updates are made to the Provider manual, Contractor must notify Network Providers, Subcontractors, and Downstream Subcontractors.

Contractor must solicit feedback from Contractor committees including but not limited to the Community Advisory Committee (CAC) and Quality Improvement Committee (QIC), to inform the development of Contractor Provider manual and clarify new and revised policies and procedures contained therein.

Contractor must conduct an annual review of its Provider manual and document that the review has been conducted by the appropriate Contractor committees including the QIC. Contractor must update its Provider manual annually or at any time to ensure that the information reflects current requirements.

Contractor's Provider manual must include and inform Network Providers, Subcontractors, and Downstream Subcontractors of the following Member rights information, as set forth in Exhibit A, Attachment III, Section 5.1 (*Member Services*):

A. Member's right to file Grievances and Appeals, and the requirements and timeframes for filing, including the right to have the Member's Medical Record and to have an Authorized Representative (AR) or Provider appeal on the Member's behalf, with written consent from the Member;

B. Availability of assistance in filing a Grievance, Appeal, or State Hearing;

C. Toll-free numbers to file oral Grievances and Appeals;

D. Member's right to request continuation of benefits during an Appeal or State Hearing;

E. Member's right to a State Hearing, how to obtain a State Hearing, and representation rules at a State Hearing; and

F. Member's right to an Independent Medical Review (IMR), if applicable.

3.2.5 Network Provider Training

Contractor must ensure that all Network Providers receive training regarding the Medi-Cal Managed Care program to ensure they operate in full compliance with the Contract and all applicable federal and State statutes, regulations, All Plan Letters (APLs), and Policy Letters (PLs). Contractor must conduct training for all Network Providers. Contractor must start training within ten Working Days and complete training within 30 Working Days after Contractor places a newly contracted Network Provider on active status. Contractor may conduct Network Provider training online or in-person. Contractor must maintain records of attendance to validate that Network Providers received training on a bi-annual basis.

A. Contractor must ensure that Network Provider training includes education on Covered Services, policies and procedures for clinical protocols governing Prior Authorization and UM, and carved out services including, how to refer to and coordinate care with agencies, programs and third parties with which Contractor has a Memorandum of Understanding (MOU) as required under this Contract.

B. Contractor must conduct ongoing training, at least once every two years, for Network Providers on required preventive healthcare services, including Early Periodic Screening, Diagnosis and Testing (EPSDT) services for Members less than 21 years of age; appropriate medical record documentation; and coding requirements. This must include training on existing Contractor data collection and reporting requirements and Quality Improvement programs to ensure required preventive services are offered and provided. This training also must include, but is not limited to, training on Population Health Management (PHM) program requirements (i.e., care management services) including referrals, health education resources, and Provider and Member incentive programs.

C. Contractor must immediately notify Network Providers when changes to its existing policies and procedures impact Network Providers' provision of Medi-Cal Covered Services to Members and not wait until the next biennial mandatory training.

D. Contractor's training must educate Network Providers on Member access, including compliance with appointment waiting time standards and ensuring telephone, translation, and language access is available for Members during hours of operation. Training must also include education on secure methods for sharing information between Contractor, Network Providers, Subcontractors, Downstream Subcontractors, Members, and other healthcare professionals. This must include training on ensuring Providers have accurate contact information for the Member and all Network Providers involved in the Member's care. Contractor must also provide training on how to refer and coordinate care for Members who need access to Excluded Services.

E. Contractor must ensure that Network Provider biennial mandatory training includes information on all Member rights specified in Exhibit A, Attachment III, Section 5.1 (*Member Services*), and diversity, equity and inclusion training (sensitivity, diversity, communication skills, and cultural competency/humility training) as specified in Exhibit A, Attachment III, Subsection 5.2.11.C. (*Cultural and Linguistic Programs and Committees*). This process must also include an educational program for Network Providers regarding health needs to include but not be limited to, the Seniors and Persons with Disabilities (SPD) population, Members with chronic conditions, Members with Specialty Mental Health Service (SMHS) needs, Members with Substance Use Disorder (SUD) needs, Members with intellectual and Developmental Disabilities (DDs), and Children and Youth with Special Health Care Needs (CYSHCN). Trainings must include Social Drivers of Health (SDOH) and disparity impacts on Members' health care. Attendance records must be reviewed and maintained by Contractor's Health Equity officer.

F. Trainings must be reviewed by the appropriate Contractor committees, including Contractor's board of director's compliance and oversight committee and QIC, routinely, but not less than biennially, to ensure consistency and accuracy with current requirements and Contractor's policies and procedures.

G. In compliance with 42 Code of Regulations (CFR) section 438.236(b), Contractor must ensure that practice guidelines are based on valid and reliable clinical evidence or a consensus of Providers in that particular field, consider the needs of Contractor's Members, are adopted in consultation with Network Providers, and are reviewed and updated periodically as appropriate. In addition to Network Provider training, Contractor must disseminate their practice guidelines to all affected Providers.

3.2.6 Emergency Department Protocols

Contractor must develop and maintain protocols for communicating and interacting with emergency departments in and out of its Service Area. Contractor's protocols must be distributed to all emergency departments in the Service Area and must include, at a minimum, the following:

A. All information on telephone or other secure methods of communicating with Contractor's triage and advice systems;

B. Contact information for Contractor's designated contact person responsible for coordinating Emergency Services who is available 24 hours a day for the coordination of Emergency Services and Post-Stabilization Care Services;

C. Written referral procedures (including after-hours instruction) that emergency department personnel can provide to Members who present at the emergency department for Non-Emergency services;

D. Procedures for emergency departments to report Contractor's system and/or protocol failures and Contractor's processes for correcting deficiencies when failures occur;

E. Procedures for the authorization and payment of Medically Necessary Post-Stabilization Care Services consistent with 42 CFR section 438.114, APL 19-008, and APL 23-009;

F. Procedures for screening and referral of Members who meet Enhanced Care Management (ECM) Populations of Focus (POF) eligibility criteria,

especially the Individuals at risk for avoidable hospital or Emergency Department utilization POF; and

G. Procedures for screening and referral of Members who meet medical necessity eligibility criteria for Community Health Workers CHW services.

3.2.7 Prohibited Punitive Action Against the Provider

Contractor is prohibited from taking punitive action against a Provider who either requests an expedited resolution or supports a Member's Appeal. Further, Contractor may not prohibit, or otherwise restrict, a health care professional acting within their lawful scope of practice, from advising, or advocating on behalf of, a Member about:

A. The Member's health status, medical care, treatment options, or alternative treatment options (including any alternative treatment that may be self-administered), including obtaining any information the Member needs in order to decide among all relevant treatment options;

B. The risks, benefits, and consequences of treatment or non-treatment; or

C. The Member's right to participate in decisions regarding their health care, including the right to refuse treatment and to express preferences about future treatment decisions.

3.2.8 Submittal of Inpatient Days Information

Contractor must report hospital inpatient days to DHCS as required by Welfare and Institutions Code (W&I) section 14105.985(b)(2). Upon DHCS' written request, Contractor must also provide these reports for the time period and in the form and manner specified in DHCS' request, within 30 calendar days of receipt of the request. Contractor must submit additional reports to DHCS, as requested, for the administration of the Disproportionate Share Hospital program.

Exhibit A, ATTACHMENT III

3.3 Provider Compensation Arrangements

3.3.1 Compensation and Value Based Arrangements
3.3.2 Capitation Arrangements
3.3.3 Provider Financial Incentive Program Payments
3.3.4 Identification of Responsible Payor
3.3.5 Claims Processing
3.3.6 Prohibited Claims
3.3.7 Federally Qualified Health Center, Rural Health Center, and Indian Health Care Provider
3.3.8 Non-Contracting Certified Nurse Midwife, Nurse Practitioner, and Licensed Midwife Providers
3.3.9 Non-Contracting Family Planning Providers
3.3.10 Sexually Transmitted Disease
3.3.11 Human Immunodeficiency Virus Testing and Counseling
3.3.12 Immunizations
3.3.13 Community Based Adult Services
3.3.14 Organ and Bone Marrow Transplants
3.3.15 Long-Term Care Services
3.3.16 Emergency Services and Post-Stabilization Care Services
3.3.17 Provider-Preventable Conditions
3.3.18 Prohibition Against Payment to Excluded Providers
3.3.19 Compliance with Directed Payment Initiatives and Related Reimbursement Requirements

3.3 Provider Compensation Arrangements

3.3.1 Compensation and Value Based Arrangements

A. Except as otherwise specified in this Contract, Contractor may compensate Providers as Contractor and Provider negotiate and agree.

B. DHCS encourages Contractor to utilize value-based and alternative payment models to compensate Network Providers, especially for Primary Care Covered Services, in ways that ensure Provider accountability for both quality and total cost of care with a focus on population health management. Contractor must monitor and must report, within 90 calendar days of DHCS' request, the number or amount, and percent, of Contractor's Members, Network Providers, and medical expenditures that are made under such payment models, separately for hospital services, professional services, and other services at a minimum.

C. Payment to support Networks based on value: To continue to build and strengthen Networks based on value, Contractors must support their Providers through value-based payment models that promote high-quality, affordable, and equitable care.

On an annual basis, as specified by DHCS, Contractor must report on its Network payment models using the Health Care Payment Learning and Action Network Alternative Payment Model (HCP LAN APM) framework categories as outlined.

D. Effective Primary Care: Contractor must support effective Primary Care and integrated care through use of alternative payment models, such as population-based payment and shared savings. Specifically, Contractor must:

1) Ensure investment in Primary Care service delivery

a) Contractor must report on total Primary Care spend, as defined by the Integrated Healthcare Association (IHA), and the percent of spend within each HCP LAN APM Framework Category. Contractor must report the percentage of spend within each HCP LAN APM Framework Category as a percentage of its total spend.

b) Contract must stratify the reporting of Primary Care spend (and as a percentage of total spend) by age (Children and youth ages zero to 20; adults ages 21+), by race/ethnicity, and as requested by DHCS.

c) Contractor must work with DHCS and other stakeholders to analyze the relationship between the percent of spend for Primary Care services with performance of the overall delivery system. If the evidence shows that rebalancing to increase Primary Care spend improves quality or drives lower total cost of care, DHCS may set a target or floor for Primary Care spend in future requirements, and Contractor will be required to meet these targets for minimum Primary Care spend.

2) Ensure promotion of Primary Care delivery through alternative payment models

a) As specified by DHCS, Contractor must report on its Primary Care payment models using the HCP LAN APM Framework Categories.

b) As specified by DHCS, Contractor must report on an annual basis the number and percent of its contracted Primary Care clinicians paid using each HCP LAN APM Framework Category.

c) A description of Contractor's payment model for its five largest medical groups, as defined by the number of Providers, and how its Primary Care clinicians are paid. Contractor must adopt and progressively expand the percent of Primary Care clinicians paid through the HCP LAN APM Framework Categories of population-based payment (Category 4) and alternative payment models built on a fee-for-service structure such as shared savings (Category 3).

3.3.2 Capitation Arrangements

Payments by Contractor to a Network Provider on a capitation basis must be payable effective the date the Member's Enrollment is assigned to the Network Provider. Capitation Payments by Contractor to a Network Provider must be payable no later than 30 calendar days after the Member Assignment.

3.3.3 Provider Financial Incentive Program Payments

A. Contractor may compensate Providers through financial incentive program payments, so long as:

1) Financial incentive program payments to Providers are not designed to induce Providers to reduce or limit Medically Necessary Covered Services provided to a Member;

2) Financial incentive program payments comply with the requirements of All Plan Letter (APL) 19-005, where applicable; and

3) All financial incentive programs related to this Contract are reported in the form, manner, and frequency specified by DHCS.

B. Contractor may implement and maintain a physician incentive plan, as defined in 42 Code of Federal Regulations (CFR) section 422.208, so long as:

1) No specific payment is made directly or indirectly under the physician incentive plan as an inducement to reduce or limit Medically Necessary Covered Services provided to a Member; and

2) The physician incentive plan complies with the requirements of 42 CFR sections 438.3(i) and 438.10(f)(3).

3.3.4 Identification of Responsible Payor

Contractor must provide information to the DHCS fiscal intermediary that identifies the payor(s) responsible for reimbursement of Covered Services provided to a Member. Contractor must identify the Network Provider, Subcontractor, or Downstream Subcontractor responsible for payment, if applicable, and the name and telephone number of the Provider responsible for providing care. Contractor must provide this information upon DHCS' request and in a manner prescribed by DHCS.

3.3.5 Claims Processing

Contractor must pay all Clean Claims submitted by Providers in accordance with this section.

A. Contractor must comply with 42 United States Code (USC) section 1396u-2(f) and Health and Safety Code (H&S) sections 1371 - 1371.39 and their implementing regulations, including 42 CFR sections 447.45 - 447.46 and 28 CCR section 1300.71. Contractor must be subject to any penalties and sanctions, including interest at the rate of 15 percent per annum, provided by law if Contractor fails to meet the standards specified in this section.

B. Contractor is expected to pay Clean Claims within 30 calendar days of receipt. Pursuant to H&S section 1371(a), if Contractor does not pay a Clean Claim within 45 Working Days of receipt, it will owe the Provider interest at the rate of 15 percent per annum beginning on the first day after a 45 Working Day period. For the purposes of calculating interest, the first day is considered to be the first calendar day after 45 Working Days

following the receipt of the claim. Contractor must automatically include all accrued interest in any late payment. Pursuant to 42 USC section 1396a(a)(37)(A) and 42 CFR section 447.45(d), Contractor must pay at least 90 percent of all Clean Claims from Providers within 30 calendar days of the date of receipt and 99 percent of all Clean Claims within 90 calendar days. For purposes of calculation, the date of receipt is considered the date Contractor receives the claim, as indicated by its date stamp on the claim, and the date of payment is considered the date of the check or other form of payment.

C. Contractor must provide direct instruction, training, and technical assistance to its Providers to support information transmission and the submission of Clean Claims, including bills or invoices submitted by ECM Providers; Community Support Providers; Doulas, or other community-based Providers that are unable to submit claims through an electronic file format. Contractor must make claiming, billing or invoicing guides and notices readily available to its Providers, including through Provider portals and/or Provider manuals. Contractor is required to train Network Providers to effectively use electronic systems to facilitate timely submission of Clean Claims, equivalent Encounters, or bills or invoices.

D. If claims are denied, rejected, or contested in whole or in part, Contractor must specify the reason(s) for contesting or denying a claim and specify the additional information necessary to complete the claim as well as offering technical assistance to remediate deficiencies.

E. Contractor must maintain procedures for pre-payment and post-payment claims review, including review of any data associated with Providers, Members, and the Covered Services for which payment is claimed.

F. Contractor must maintain sufficient claims processing, tracking, and payment systems capability to comply with applicable State and federal law, regulations, and Contract requirements, to determine the status of received claims and to provide an Incurred but Not Reported Claim Estimate as specified by 28 CCR sections 1300.77.1 and 1300.77.2.

3.3.6 Prohibited Claims

A. Contractor must comply with 22 CCR sections 53866, 53220, and 53222 regarding the submission and recovery of claims for services provided under this Contract. Contractor must ensure that its Subcontractors and Downstream Subcontractors also comply with 22 CCR sections 53866, 53220, and 53222.

B. Contractor must hold harmless and indemnify Members for Contractor's debt to Providers for services rendered and billed to Members.

3.3.7 Federally Qualified Health Center, Rural Health Center, and Indian Health Care Provider

A. Reimbursement of Non-Contracting Federally Qualified Health Centers (FQHCs) and Rural Health Center (RHCs)

If FQHC and RHC services are not available in Contractor's Network in a particular county of Contractor's Service Area, Contractor must reimburse non-contracting FQHCs and RHCs for Covered Services in that county provided to Members at a level and amount of payment that is not less than the level and amount of payment which the entity would make for the services if the services were furnished by a Provider which is not a FQHC or RHC.

B. Required Terms and Conditions for Network Provider Agreements with FQHCs and RHCs

1) Contractor must submit to DHCS, within 30 calendar days of a request and in the form and manner specified by DHCS, documentation of the services provided, the reimbursement level, and amount for each of Contractor's FQHC and RHC Network Provider Agreements.

2) Contractor must certify in writing to DHCS within 30 calendar days of DHCS' written request that, pursuant to Welfare and Institutions Code (W&I) sections 14087.325(b) and (d), Contractor's Network Provider Agreement terms and conditions with FQHCs and RHCs are the same as those offered to other Network Providers providing similar services, and that reimbursement is not less than the level and amount of payment which the entity would make for the services if the services were furnished by a Provider which is not a FQHC or an RHC.

3) Contractor is not required to pay FQHCs and RHCs the Medi-Cal per-visit rate for that clinic.

4) Contractor must fully cooperate with any DHCS review and audit of Contractor's operations and records related to FQHC and RHC reimbursement to ensure compliance with State and federal law.

5) Contractor must submit any FQHC and RHC Network Provider Agreements to DHCS for approval in accordance with W&I section 14087.325.

6) To the extent that an Indian Health Care Provider (IHCP) Facility chooses to participate as an FQHC or RHC, the above requirements in this Paragraph B must apply to a Network Provider Agreement with an IHCP. Moreover, Contractor must pay any non-contracted IHCP that qualifies as an FQHC or RHC an amount equal to what Contractor would pay a contracted FQHC or RHC, and DHCS must make any additional payment needed to comply with 42 CFR section 438.14(c).

7) Contractor or its Subcontractors and Downstream Subcontractors may enter into financial incentive payment arrangements with FQHC and RHC Network Providers provided such agreements meet all applicable conditions of federal and State law and of APL 19-005 including, but not limited to, the following:

   a) Contractor must establish and maintain clear, objective criteria for the financial incentive payments and the conditions under which payments will be made.

   b) The financial incentive payment arrangement must enumerate specific metrics and/or performance terms for the FQHC or RHC to attain the financial incentive payment.

   c) Contractor must have written agreements in place with the FQHC or RHC prior to the start of the financial incentive payment arrangement, including the methodology used to determine the total incentive payment amount.

   d) The financial incentive payments must be similar to, and not less in amount than, other financial incentive payments Contractor makes to non-FQHC or non-RHC Network Providers who are providing similar services.

   e) Financial incentive payment arrangements must not result in payments that are less than the payments made by Contractor to non-FQHC or non-RHC Network Providers who are providing similar services.

   f) Contractor must evaluate the effectiveness of the financial incentive payments and adjust or discontinue them if they are determined ineffective upon evaluation.

   g) Contractor must provide to DHCS, upon request, written agreements for, as well as policies and procedures for oversight and monitoring of, such financial incentive payments.

C. Indian Health Care Providers

1) Contractor must attempt to contract with each IHCP in its Service Area as set forth in 22 CCR sections 55120 - 55180. Contractor must reimburse an IHCP that qualifies as a FQHC but is not a Network Provider as set forth in 42 CFR section 438.14(c)(1).

2) For services provided to Members who are qualified to receive services from an IHCP pursuant to the California Medicaid State Plan, Supplement 6, Attachment 4.19-B, regardless of whether the IHCP is a Network Provider:

a) Contractor must reimburse IHCP at the most current and applicable outpatient per-visit rate published in the Federal Register by the Indian Health Service (IHS) in accordance with APL 17-020 and APL 21-008.

b) Contractor must ensure compliance with any retroactive changes to the outpatient per-visit rates published in the Federal Register by the IHS by appropriately reimbursing IHCPs in accordance therewith.

c) Contractor must reimburse IHCPs at the Medi-Cal Fee-For-Service (FFS) Rate for services that, pursuant to the California Medicaid State Plan, Supplement 6, Attachment 4.19-B, are not eligible for the outpatient per-visit rate published in the Federal Register by the IHS.

3.3.8 Non-Contracting Certified Nurse Midwife, Nurse Practitioner, and Licensed Midwife Providers

In accordance with 22 CCR section 51345 *et seq*. and APL 18-022, if there are no contracted Certified Nurse Midwife (CNM), Nurse Practitioner (NP), or Licensed Midwife (LM) Providers in Contractor's Network, Contractor must reimburse non-contracting CNMs, NPs, or LMs for services provided to Members at no less than the applicable Medi-Cal FFS Rates. For hospitals, the requirements of Exhibit A, Attachment III, Subsection 3.3.16.A.3 (*Emergency Services*), if applicable, apply. For Free Standing Birthing Centers, Contractor must reimburse non-contracting Free Standing Birthing Centers at no less than the applicable Medi-Cal FFS Rate. If an appropriately licensed non-contracting Free Standing Birthing Center is used, Contractor also must pay the Center's facility fee.

3.3.9 Non-Contracting Family Planning Providers

Pursuant to federal law, including but not limited to 42 USC sections 1396a(a)(23) and 1396n(b) and 42 CFR section 431.51, Contractor must reimburse non-contracting family planning Providers at no less than the appropriate Medi-Cal FFS Rate, for services listed in Exhibit A, Attachment III, Subsection 5.2.8 (*Specific Requirements for Access to Programs and Covered Services*), provided to Members of childbearing age to temporarily or permanently prevent or delay pregnancy.

3.3.10 Sexually Transmitted Disease

Pursuant to federal law, including but not limited to 42 USC sections 1396a(a)(23) and 1396n(b) and 42 CFR section 431.51, Contractor must reimburse non-contracted family planning Providers, including local health departments, at no less than the Medi-Cal FFS Rate for the diagnosis and treatment of a Sexually Transmitted Disease (STD) episode, as defined in Policy Letter (PL) 96-09. Contractor must provide reimbursement only if the STD treatment Provider provides treatment records or documentation of the Member's refusal to release Medical Records to Contractor along with billing information.

3.3.11 Human Immunodeficiency Virus Testing and Counseling

Pursuant to federal law, including but not limited to 42 USC sections 1396a(a)(23) and 1396n(b) and 42 CFR section 431.51, Contractor must reimburse non-contracting family planning Providers, including local health departments, at no less than the Medi-Cal FFS Rate for Human Immunodeficiency Virus (HIV) testing and counseling in accordance with PL 97-08. Contractor must provide reimbursement only if such non-contracting family planning Providers make reasonable efforts to report confidential test results to Contractor in accordance with applicable laws and regulations, including but not limited to H&S section 121025 *et seq*.

3.3.12 Immunizations

Contractor must reimburse local health departments for the administration fee for immunizations given to Members, in accordance with the terms set forth in APL 18-004, who are not already immunized as of the date of the immunization. The local health department must provide immunization records when immunization services are billed to Contractor. Other than local health departments, Contractor is not obligated to reimburse Providers for immunizations under this provision unless the Provider enters into an agreement with Contractor.

3.3.13 Community Based Adult Services

Contractor must reimburse Network Providers for Community Based Adult Services (CBAS) pursuant to a reimbursement structure that must include an all-inclusive per-Member, per-day of attendance rate, or otherwise be reflective of

the acuity and/or level of care of the Member population served by Network Providers of CBAS. In accordance with W&I section 14184.201(d)(4), Contractor must reimburse Network Providers of CBAS the amount the Provider could collect if the Member accessed those services in the FFS delivery system, as defined by DHCS in the California Medicaid State Plan and other applicable guidance, including but not limited to guidance issued pursuant to W&I section 14184.102(d), unless Contractor and the Network Provider mutually agree to reimbursement in a different amount. Contractor may include incentive payment adjustments and performance and/or quality standards in its rate structure in paying Network Providers of CBAS.

3.3.14 Organ and Bone Marrow Transplants

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

3.3.15 Long-Term Care Services

In accordance with W&I sections 14184.201(b) and (c), and for applicable dates of service, Contractor must reimburse a Network Provider furnishing institutional Long-Term Care LTC services to a Member the amount the Provider could collect if the Member accessed those services in the FFS delivery system, as defined by DHCS in the California Medicaid State Plan, a Directed Payment Initiative, and other applicable guidance, including but not limited to guidance issued pursuant to W&I section 14184.102(d). As used in this provision, “institutional LTC services” has the same meaning as set forth in the California Advancing and Innovating Medi-Cal (CalAIM) Terms and Conditions and, subject to W&I section 141814.201(g), includes, at a minimum, all of the following services: Skilled Nursing Facility (SNF) services; subacute facility services; pediatric subacute facility services; and Intermediate Care Facility for the Developmentally Disabled (ICF/DD), ICF/DD-Habilitative (ICF/DD-H), and ICF/DD-Nursing (ICF/DD-N) services.

3.3.16 Emergency Services and Post-Stabilization Care Services

A. Emergency Services

1) Subject to 42 CFR section 422.113(b), Contractor is responsible for coverage and payment of Emergency Services and must cover and pay for Emergency Services regardless of whether the Provider that furnishes the services has a contract with Contractor.

Contractor must not deny payment for treatment obtained when a Member had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 CFR section 438.114(a)(i) – (iii). Further, Contractor must not deny payment for treatment obtained when a representative of Contractor instructs the Member to seek Emergency Services. Emergency Services must not be subject to Prior Authorization by Contractor.

2) Contractor must not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms or refuse to reimburse Emergency Services based on the emergency room Provider, hospital, or fiscal agent not notifying the Member's Primary Care Providers, Contractor, or DHCS of the Member's screening and treatment for Emergency Services. A Member who has an Emergency Medical Condition must not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the Member.

3) Contractor must reimburse Providers for Emergency Services received by a Member from out-of-Network Providers. Payments to non-contracting Providers must be for the treatment of the Emergency Medical Condition, including Medically Necessary inpatient services rendered to a Member until the Member's condition has stabilized sufficiently to permit referral and transfer in accordance with instructions from Contractor or the Member is stabilized sufficiently to permit discharge. The treating Provider is responsible for determining when the Member is sufficiently stabilized for transfer or discharge and that determination is binding on Contractor. Emergency Services must not be subject to Prior Authorization by Contractor.

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

5) For all non-contracted Emergency Services Providers, reimbursement by Contractor or by a Subcontractor or Downstream Subcontractor who is at risk for out-of-Network Emergency Services for properly documented claims for services rendered by out-of-Network Provider pursuant to this provision must be made in

accordance with Exhibit A, Attachment III, Subsection 3.3.5 (*Claims Processing*) above and 42 USC section 1396u-2(b)(2)(D).

B. Post-Stabilization Care Services

1) Except for the response time periods set forth in 42 CFR section 422.113(c)(2)(ii) and (iii)(A), Post-Stabilization Care Services must be covered by and paid for in accordance with 42 CFR section 422.113(c) and APL 23-009. Applicable response time periods involving Post-Stabilization Care Services is governed by Exhibit A, Attachment III, Subsection 2.3.2(B) (*Timeframes for Medical Authorization*) of this Contract and APL 23-009. Contractor is financially responsible for Post-Stabilization Care Services obtained within or outside Contractor's Network that are authorized by Contractor, Subcontractor, or Downstream Subcontractor.

2) In accordance with 28 CCR section 1300.71.4, Contractor must approve or disapprove a request for Post-Stabilization Care Services made by a Provider on behalf of a Member within 30 minutes of the request. If Contractor fails to approve or disapprove authorization within the required timeframe, the authorization is deemed approved.

3) Contractor is also financially responsible for Post-Stabilization Care Services obtained within or outside Contractor's Network that are not authorized by Contractor, Subcontractor, or Downstream Subcontractor, but administered to maintain, improve, or resolve the Member's stabilized condition if Contractor, Subcontractor, or Downstream Subcontractor does not respond to a request for authorization within 30 minutes; Contractor, Subcontractor, or Downstream Subcontractor cannot be contacted; or Contractor, Subcontractor, or Downstream Subcontractor and the treating Provider cannot reach an agreement concerning the Member's care. In this situation, the treating Provider may continue with care of the Member until Contractor, Subcontractor, or Downstream Subcontractor is reached and assumes responsibility for the Member's care or one of the criteria of 42 CFR section 422.113(c)(3) is satisfied.

4) Contractor's financial responsibility for Post-Stabilization Care Services it has not authorized ends when a Network Provider with privileges at the treating hospital assumes responsibility for the Member's care; a Network Provider assumes responsibility for the Member's care through transfer; Contractor's Representative and the treating Provider reach an agreement concerning the Member's care; or the Member is discharged.

5) Consistent with 42 CFR sections 438.114(e), 422.113(c)(2), and 422.214, Contractor is financially responsible for payment of Post-Stabilization Care Services, following an emergency admission, at the hospital's Medi-Cal FFS Rate for general acute care inpatient services rendered by a non-contracting, Medi-Cal certified hospital, unless a lower rate is agreed to in writing and signed by the hospital.

a) For the purposes of this Subsection 3.3.16 (*Emergency Services and Post-Stabilization Care Services*), the FFS payment amounts for dates of service when the Post-Stabilization Care Services were rendered must be the FFS payment method known as diagnosis-related groups, which for the purposes of this Paragraph 5 must apply to all acute care hospitals, including public hospitals that are reimbursed under the certified public expenditure basis methodology (W&I section 14166 *et seq.*), less any associated direct or indirect medical education payments to the extent applicable.

b) Payment made by Contractor to a hospital that accurately reflects the payment amounts required by this Paragraph 5 must constitute payment in full and must not be subject to subsequent adjustments or reconciliations by Contractor, except as provided by Medicaid law and regulations. A hospital's tentative and final cost settlement processes required by 22 CCR section 51536 must not have any effect on payments made by Contractor pursuant to this Paragraph 5.

C. Disputed claims involving Emergency Services and/or Post-Stabilization Care Services may be submitted for resolution under provisions of W&I section 14454 and 22 CCR section 53620 *et seq.* (except section 53698) to:

Department of Health Care Services
Office of Administrative Hearings and Appeals
3831 North Freeway Blvd, Suite 200
Sacramento, CA 95834

Contractor agrees to implement DHCS' determination and reimburse the out-of-Network Provider within 30 calendar days of the effective date of a decision that Contractor is liable for payment of a claim and must provide proof of reimbursement in such form as DHCS directs. Failure to reimburse the out-of-Network Provider within 30 calendar days must result

in capitation offsets in accordance with W&I sections 14454(c) and 14115.5 and 22 CCR section 53702 and may subject Contractor to sanctions pursuant to W&I section 14197.7.

3.3.17 Provider-Preventable Conditions

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

3.3.18 Prohibition Against Payment to Excluded Providers

In accordance with 42 USC section 1396b(i)(2), Contractor must not pay any amount for any services or items, other than Emergency Services, to an Excluded Provider as described in Exhibit A, Attachment III, Subsection 1.3.4 (*Contractor's Obligations Regarding Suspended, Excluded, and Ineligible Providers*) and in APL 21-003.

3.3.19 Compliance with Directed Payment Initiatives and Related Reimbursement Requirements

Contractor must reimburse eligible Providers in accordance with the terms of applicable Pass-Through Payments and Directed Payment Incentives as specified in Exhibit B, Section 1.14 (*Special Contract Provisions Related to Payment*). Contractor must provide Provider-level data to DHCS and Providers eligible for Directed Payment Initiatives in accordance with APL 25-015 or other technical guidance.

Exhibit A, ATTACHMENT III

4.0 Member

DHCS is committed to ensuring that the Medi-Cal Member's experience is at the center of health care delivery from the point of Enrollment into a managed care plan throughout their time as a Member.

This Article makes explicit DHCS' commitment to a comprehensive population health managed approach that ensures all Members have equitable access to necessary wellness and prevention services, Care Coordination, Complex Care Management (CCM), Transitional Care Services, and Enhanced Care Management (ECM). From assessing the needs of Members on a population basis, to identifying and stratifying Members' risk on an individual basis, Contractors are required to have the systems (including data analytic capabilities), processes, and people (including ECM Providers in network with direct experience working with specific Populations of Focus) to support appropriate Population Health Management functions.

This Article also makes explicit DHCS' commitment to ensure that Members are appropriately accessing Covered Services, including when they are referred to community-based Providers. For example, Contractor must ensure referrals to services provided by Community Health Workers (CHWs), peer counselors, and local community organizations providing Community Support services.

This Article includes provisions that directly address Social Drivers of Health (SDOH) – from capturing and tracking SDOH data to providing Community Support services. Community Support services, such as medically tailored meals and short-term post-hospitalization services, are intended to address SDOH and can be provided by Contractors to the extent they are medically appropriate substitutes for Covered Services.

Finally, this Article outlines provisions related to Grievances and Appeals which includes processes by which Contractors must inform Members of their rights and ensure seamless processes by which Members can exercise their rights. DHCS also includes reporting requirements to enable DHCS to effectively monitor, oversee, and enforce Contract provisions when needed.

4.1 Marketing

4.1.1 Training and Certification of Marketing Representatives
4.1.2 Marketing Plan

4.1 Marketing

4.1.1 Training and Certification of Marketing Representatives

Before conducting any Marketing, Contractor must develop a training and certification program for Contractor's Marketing Representatives and ensure that all staff performing any Marketing activities or distributing Marketing Materials are appropriately certified.

A. Contractor is responsible for all Marketing activities conducted on its behalf. Contractor is liable for all violations committed by any of its Marketing Representatives. Marketing staff must not provide Marketing services for more than one Contractor, and Marketing strategies must align with Contractor's efforts in improving Health Equity. Marketing Representatives must not engage in Marketing practices that illegally discriminate against a Member or Potential Member on the basis of any characteristic protected by federal or State law. Such protected characteristics include, without limitation, sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, health status, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code section 422.56. Contractor must ensure all Marketing activities and Marketing Materials are culturally and linguistically competent in compliance with Exhibit A, Attachment III, Subsection 5.1.3 (*Member Information*) and Exhibit A, Attachment III, Subsection 5.2.11 (*Cultural and Linguistic Programs and Committees*).

B. Training Program

Contractor must develop a training program that will train staff and prepare Marketing Representatives for certification. Prior to implementation, Contractor must obtain written approval from DHCS for Contractor's training and certification program, and any changes in the program. Contractor must develop and provide to Marketing Representatives a staff orientation and Marketing Representative training/certification manual. At a minimum, the manual must explain:

1) The Medi-Cal program, including Medi-Cal Fee-For-Service (FFS), Medi-Cal managed care, Network Providers, Subcontractors, Downstream Subcontractors, and program eligibility;

2) The Medi-Cal scope of services;

3) Contractor's administrative operations and health delivery system program, including the Service Area covered, Excluded Services,

additional services, conditions of Member Enrollment, and aid categories;

4) Contractor's Utilization Management policy, including, but not limited to, how Members are obligated to obtain all Non-Emergency medical care through Contractor's Network and a description of all prerequisites to medical care and other health care services, such as referrals and Prior Authorizations;

5) Contractor's Grievance and Appeals procedures; the State Hearing process; and, as applicable to Contractor's plan model, the Independent Medical Review (IMR) process;

6) When Members can disenroll from Contractor, including qualifying conditions for both voluntary and mandatory disenrollment;

7) Contractor's obligation to keep confidential any information obtained from Members and Potential Members, including information regarding eligibility under any public welfare or social services program;

8) How Contractor will supervise and monitor its Marketing Representatives and staff to ensure compliance with applicable statutes and regulations;

9) The types of acceptable and prohibited communication methods and sales techniques Marketing Representatives may or may not use;

10) Contractor's anti-discrimination policy and the prohibition against the Enrollment or failure to enroll a Member or Potential Member due to a pre-existing medical condition (except for conditions requiring Excluded Services); and

11) The consequences of Marketing misrepresentation and Abuse, including, but not limited to, discipline, suspension of Marketing activities, termination, and civil and criminal prosecution. The Marketing Representative and Contractor must understand that any Abuse of Marketing requirements can result in termination of this Contract.

4.1.2 Marketing Plan

Before conducting any Marketing, or implementing any Marketing plan, Contractor must develop and obtain DHCS written approval for its Marketing plan or changes to a Marketing plan as specified below. The Marketing plan must be

specific to the Medi-Cal program only and Marketing Materials must be distributed within Contractor's entire Service Area. Contractor must ensure that the Marketing plan and all related materials are accurate and do not mislead, confuse, or defraud Members, Potential Members, or the Medi-Cal program.

A. Contractor must submit a Marketing plan to DHCS for review and approval on an annual basis and any time Contractor desires to change its Marketing plan. The Marketing plan, whether new or revised, must describe all of Contractor's current and proposed Marketing, including, but not limited to, all procedures, activities, events, and methods.

B. Contractor's Marketing plan must contain the following:

1) A table of contents section that divides the Marketing plan into chapters, sections, or pages. Each page must be dated and numbered so that chapters, sections, or pages can be easily identified and replaced when revised.

2) A mission statement or statement of purpose for the Marketing plan.

3) An organizational chart including key staff positions and the Marketing director's name, address, telephone, and facsimile number.

4) A narrative description explaining how Contractor's internal Marketing department operates by identifying key staff positions, roles, and responsibilities. The narrative must also report relationships including, if applicable, how Contractor's commercial Marketing staff and functions interface with Contractor's Medi-Cal Marketing staff and functions.

5) Copies of all Member incentives Contractor will distribute during any Marketing event or through any other Marketing activities, in accordance with All Plan Letter (APL) 16-005.

6) An explicit description of all of Contractor's expected Marketing methods and activities.

7) Documentation of all agreements between Contractor and the organizations with which it is undertaking Marketing activities.

8) All Marketing Materials Contractor will use, including those for English-speaking populations, non-English speaking populations, and alternative formats for people with disabilities (including Braille,

large-size print font no smaller than 20-point, accessible electronic format, and audio format).

9) A description of the methods Contractor will use to distribute Marketing Materials in compliance with APLs, this Contract, and State and federal law, including, but not limited to, the Telephone Consumer Protection Act of 1991 (47 United States Code (USC) section 227).

10) Copies of a sample Marketing identification badge and business card clearly identifying Marketing Representatives as Contractor's employees. Marketing identification badges and business cards must not resemble those of a government agency.

11) Written formal procedures for monitoring the performance of Contractor's Marketing Representatives to ensure Marketing integrity, pursuant to Welfare and Institutions Code (W&I) section 14408(c).

12) All sites for proposed Marketing activities, such as annual health fairs and community events in which Contractor proposes to participate.

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

C. If Contractor wishes to conduct a Marketing activity not included in the approved Marketing plan, Contractor must submit a written request and obtain prior written approval for that Marketing activity from DHCS. Contractor must submit the written request, a copy of the proposed Marketing Materials, and all other required documentation at least 30 calendar days prior to the Marketing activity, unless DHCS agrees to a shorter review period.

D. At least 30 calendar days before Contractor's participation in any proposed Marketing events, Contractor must notify its designated DHCS Contract Manager in writing and provide required documentation for DHCS review and approval. In cases where Contractor learns of a Marketing event less than 30 calendar days before the event, Contractor must immediately provide written notification and required documentation to DHCS for review and approval. In no instance may notification be less than two Working Days before the Marketing event.

E. At least 30 calendar days before Contractor's participation in any proposed Marketing events, Contractor must submit a community event Marketing agreement for DHCS review and approval. Along with the

community event Marketing agreement, there must be an attestation from the event organization stating that:

1) Contractor will not distribute Marketing Materials or conduct Marketing presentations at a Network Provider, Subcontractor, Downstream Subcontractor, or out-of-Network Provider site, including hospitals and their property; and

2) There are trained Marketing staff at the Marketing event and, if the Marketing event is educational, there are trained health educators at the Marketing event.

F. Contractor must obtain prior DHCS approval before performing in-home Marketing presentations and must provide strict accountability, including documentation from the Potential Member requesting an in-home Marketing presentation or a telephone log entry documenting the Potential Member's request.

G. Contractor must submit any advertisement intended for Marketing purposes to DHCS for prior approval. Such advertisements include, but are not limited to, mass media, magazines, newspapers, radio, telephonic Marketing, TV, billboards, bus sides, and any mobile advertisements.

H. Contractor must not position any mobile advertisements at any Network Provider, Subcontractor, Downstream Subcontractor, or non-contracted Provider sites, including hospitals and their property.

I. When conducting Marketing, Contractor must comply with W&I sections 10850(b), 14407.1, 14408, 14409, 14410, and 14411 and 22 California Code of Regulations (CCR) sections 53880 and 53881.

J. Contractor must not engage in door-to-door, telephone, e-mail, texting, or other Cold-Call Marketing for the purpose of enrolling Potential Members, or for any other purpose.

K. Contractor must not distribute Marketing Materials or conduct Marketing presentations at any Network Provider, Subcontractor, Downstream Subcontractor, or out-of-Network Provider sites, including hospitals and their property.

L. Contractor must not seek to influence Enrollment in conjunction with the sale or offering of any private insurance.

M. Contractor's Marketing Materials must not contain any statements that suggest Enrollment is necessary to obtain or to avoid losing Medi-Cal

benefits, or that Contractor is endorsed by DHCS, Center for Medicare & Medicaid Services (CMS), or any other State or federal government entity.

N. All of Contractor's Marketing must be accurate and not mislead, confuse, or defraud Members, Potential Members, or the Medi-Cal program, pursuant to 42 Code of Federal Regulations (CFR) section 438.104.

Exhibit A, ATTACHMENT III

4.2 Enrollments and Disenrollments

4.2.1 Enrollment
4.2.2 Disenrollment

4.2 Enrollments and Disenrollments

4.2.1 Enrollment

Contractor must cooperate with the DHCS Enrollment processes and the DHCS Enrollment contractor in enrolling all Potential Members into Medi-Cal managed care health plans. DHCS and its Enrollment contractor will verify eligibility status and notify the Potential Member of the available Medi-Cal managed care health plans in their County. Contractor must ensure mandatory and voluntary Potential Members residing in its Service Area, are properly enrolled pursuant to the requirements of this provision.

A. Non-Discrimination in Enrollment

Contractor must accept as Members all Potential Members who select or are assigned to Contractor without regard to sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, pre-existing medical condition(s), genetic information, health status, marital status, gender, gender identity, sexual orientation, existing or prior involvement in the justice system, or identification with any other persons or groups defined in California Penal Code section 422.56.

B. Enrollment Processing Criteria

1) Contractor must accept as Members all Potential Members who meet the Enrollment criteria in 22 California Code of Regulations (CCR) section 53845, as follows:

a) Potential Members with a Mandatory aid code unless they qualify for an exemption from Enrollment pursuant to 22 CCR section 53887 or meet the criteria in 22 CCR section 53891(c).

b) Potential Members with a Mandatory aid code who are default enrolled because they did not select a Medi-Cal managed care plan during the choice timeframe.

c) Potential Members with a Justice Involved aid code who are default enrolled per the Justice Involved Reentry Initiative, as described in the Policy and Operational Guide for Planning and Implementing CalAIM Justice-Involved Reentry Initiative.

d) Potential Members with a Voluntary aid code who select Contractor as their Medi-Cal managed care plan.

C. Enrollment Process

1) Contractor will receive an effective Enrollment date from DHCS that is no later than 90 calendar days from the date that Medi-Cal Eligibility Data System (MEDS) lists the individual as meeting the required Enrollment criteria contained in 22 CCR section 53845(a).

2) DHCS or its Enrollment contractor will assign Potential Members meeting the Enrollment criteria contained in 22 CCR section 53845(a) to Medi-Cal Managed Care Health Plans in accordance with 22 CCR section 53884, if the Potential Member fails to select a plan after receiving notice that they are required to enroll in Medi-Cal Managed Care.

3) Notwithstanding any other provision in this Contract, Paragraphs 1) and 2) above do not apply to Potential Members without a current valid deliverable address or with an address designated as a county post office box for homeless Members.

D. Enrollment Disputes

1) Contractor must notify DHCS of Enrollment disputes, pursuant to the requirements and procedures contained in Exhibit E, Section 1.21 (*Contractor's Dispute Resolution Requirements*).

2) DHCS has 120 calendar days from the date of DHCS' receipt of Contractor's Enrollment dispute notice (the "cure period") to make necessary Enrollment corrections or adjustments, identified in Contractor's dispute notice, without incurring any financial liability to Contractor. For purposes of this Provision, DHCS will be deemed to have corrected or adjusted any issues identified in Contractor's notice if, within the cure period, any of the following occurs:

a) Mandatory plan Members receive an effective Member Assignment date that is within the cure period; or

b) DHCS corrects or adjusts an Enrollment issue by redirecting Enrollment from Contractor to another Contractor within the cure period; or

c) Within the cure period, DHCS changes the distribution of Member Assignment, subject to the requirements of 22 CCR section 53845, to the maximum extent new Members are available to be assigned, to adjust for the number of incorrectly assigned Members.

3) If it is necessary to redirect Enrollment or change the distribution of Member Assignment and such change varies from the requirements of 22 CCR section 53884(b)(5) or (b)(6), Contractor agrees it will neither seek legal nor equitable relief for such variance or the results of such variance if DHCS resumes assignment consistent with 22 CCR sections 53884(b)(5) or (b)(6) after any necessary Enrollment correction or adjustment.

4) DHCS will not be financially liable to Contractor for any Enrollment dispute, in an affected county (on a county-by-county basis) if Contractor's loss of mandatory plan Members, in a month in which a dispute occurs, is less than 5 percent of Contractor's total Members in that affected county. The parties acknowledge that the above referenced 5 percent threshold will apply on a county-by-county basis, not in the aggregate. DHCS' financial liability must not exceed 15 percent of Contractor's monthly Capitation Payment.

E. Coverage

1) Member coverage begins at 12:01 a.m. on the first day of the calendar month for which the Potential Member's name is included on the list of new Members assigned to Contractor. The term of Enrollment continues indefinitely until this Contract expires, is terminated, or the Member is disenrolled pursuant to the conditions described in Exhibit A, Attachment III, Subsection 4.2.2 (*Disenrollment*) below.

2) Contractor must authorize and provide coverage for Medically Necessary Covered Services to a Child born to a Member for the month of birth and the following month. No additional Capitation Payment is owed Contractor for the services provided to the newborn Child for month of birth and the month following birth.

F. Temporary Exemption from Mandatory Enrollment

A Member in a mandatory aid code category who currently has a DHCS approved medical exemption request pursuant to 22 CCR section 53887 will not be assigned to Contractor until the medical exemption expires or the medical exemption is subsequently denied by DHCS.

G. Mandatory Assignment Restrictions

Assignment will continue on a monthly basis unless restricted by DHCS. DHCS will impose assignment restrictions and provide written notice to Contractor at least ten calendar days prior to the start of the restriction

period. DHCS will notify Contractor at least ten calendar days before the end of the restriction period.

4.2.2 Disenrollment

DHCS or its agent will process a Member's disenrollment from Contractor under the following conditions, in accordance with the provisions of 22 CCR section 53891:

A. Disenrollment from Contractor is mandatory when:

1) The Member requests disenrollment with a request for Enrollment in the competing Medi-Cal managed care plan pursuant to 22 CCR section 53891(c), subject to any lock in restrictions on disenrollment under the federal lock in option, if applicable, or when the Member enrolls in a Medicare Advantage plan that is affiliated with a competing Medi-Cal managed care plan.

2) The Member is no longer eligible for Enrollment with Contractor because they lost Medi-Cal eligibility, including the death of a Member.

3) Contractor's contract is terminated or Contractor no longer participates in the Medi-Cal Program.

4) Enrollment was in violation of 22 CCR section 53891(a)(2), or requirements of this Contract regarding Marketing.

5) The Member requests disenrollment in accordance with Welfare and Institutions Code (W&I) section 14303.1, following a merger with other organizations, or W&I section 14303.2, following a reorganization or merger, with a parent or subsidiary corporation. In these circumstances, Contractor must give Members the option to disenroll for any cause, and request Enrollment in another Medi-Cal managed care plan within 60 calendar days following the date of the reorganization or merger. Contractor must not disenroll the Member to Fee-For-Service (FFS).

6) A Member's change of residence is outside of Contractor's Service Area.

Mandatory disenrollment from Contractor will be effective on the first day of the next month after DHCS receives all documentation it determines are necessary to process the disenrollment, provided disenrollment was requested at least 30 calendar days prior to that date.

B. Except as provided in above Paragraph A.6) of this Subsection, Enrollment terminates no later than midnight on the last day of the first calendar month after DHCS receives the Member's disenrollment request and all required supporting documentation for Enrollment in a competing plan. On the first day after Enrollment ceases, Contractor is relieved of all obligations to provide Covered Services to the Member under the terms of this Contract. Contractor agrees in turn to return to DHCS any Capitation Payment forwarded to Contractor for Members no longer enrolled with Contractor under this Contract.

C. Contractor must implement and maintain procedures to ensure that all Members requesting disenrollment are provided an explanation of the Member's right to disenroll at any time, with the requirement that the Member enroll in the competing Medi-Cal managed care plan in the county, subject to the requirements in 22 CCR section 53891(c), and any restricted disenrollment period. Additionally, Contractor must immediately refer Members requesting disenrollment from Contractor to the DHCS Enrollment contractor so the Member may be enrolled in another Medi-Cal managed care plan or disenrolled because they require a carved-out service.

Exhibit A, ATTACHMENT III

4.3 Population Health Management and Coordination of Care

4.3.1 Population Health Management Program Requirements
4.3.2 Population Needs Assessment
4.3.3 Data Integration and Exchange
4.3.4 Medi-Cal Connect (DHCS' PHM Service)
4.3.5 Population Risk Stratification and Segmentation, and Risk Tiering
4.3.6 Screening and Assessments
4.3.7 Care Management Programs
4.3.8 Basic Population Health Management
4.3.9 Other Population Health Requirements for Children
4.3.10 Transitional Care Services
4.3.11 Targeted Case Management Services
4.3.12 Mental Health Services
4.3.13 Alcohol and Substance Use Disorder Treatment Services
4.3.14 California Children's Services
4.3.15 Services for Persons with Developmental Disabilities
4.3.16 School-Based Services
4.3.17 Dental
4.3.18 Direct Observed Therapy for Treatment of Tuberculosis
4.3.19 Women, Infants, and Children Supplemental Nutrition Program
4.3.20 Home and Community-Based Services Programs
4.3.21 In-Home Supportive Services
4.3.22 Indian Health Care Providers
4.3.23 Justice Involved Reentry Coordination
4.3.24 Managed Care Liaisons

4.3 Population Health Management and Coordination of Care

4.3.1 Population Health Management Program Requirements

A. Contractor must develop and maintain a Population Health Management (PHM) program that ensures all Members have equitable access to necessary wellness and prevention services, Care Coordination and care management. Contractor must assess Member needs across the continuum of care based on Member preferences, data-driven risk stratification, identified gaps in care and standardized assessment processes at both the individual Member level, and at the community level. Contractor must maintain a PHM program that seeks to improve the health outcomes of all Members consistent with the requirements set forth in this Section and DHCS guidance. Contractor must report on PHM program operations, effectiveness, and outcomes based on DHCS guidance specified in the PHM Policy Guide, as noted in All Plan Letter (APL) 22-024.

B. Contractor must ensure its PHM program meets, at a minimum, all National Committee for Quality Assurance (NCQA) PHM standards as well as applicable federal and State requirements as set forth in APL 22-024. As described in Exhibit A, Attachment III, Subsection 4.3.2 (*Population Needs Assessment*) and in accordance with APL 23-021, Contractor must fulfill its Population Needs Assessment (PNA) requirement by meaningfully participating in the local health jurisdiction (LHJ) Community Health Assessment (CHA)/ Community Health Implementation Plan (CHIP) process in the Service Area county(ies) in which it operates, and submit a PHM Strategy, informed by PNA findings, to DHCS. PHM Strategy submission documentation will include an NCQA-approved PHM strategy for accredited Plans. Contractor that has not yet obtained NCQA accreditation is still responsible for submitting PHM Strategy documentation prepared for near-future NCQA submission in line with NCQA Health Plan Accreditation standards, inclusive of population assessment documentation informing PHM Strategy and accreditation application process if Contractor is without current accreditation, upon DHCS request.

4.3.2 Population Needs Assessment

A. Contractor must conduct a Population Needs Assessment (PNA) by participating in the CHA/CHIP processes led by Local Health Departments (LHDs) in the Service Area county(ies) where Contractor operates, as defined further in APL 23-021 and the PHM Policy Guide.

B. Contractor operating in multiple LHD jurisdictions must participate in the CHA/CHIP process for each jurisdiction in which it operates.

C. Contractor must submit an annual PHM Strategy that demonstrates that Contractor is responding to community needs and provides PHM updates as specified and, in the format prescribed by DHCS.

D. Contractor must ensure that any populations covered by a Fully Delegated Subcontractor, Partially Delegated Subcontractor, or Downstream Subcontractor are included in the PNA and PHM Strategy process.

E. Contractor must publish on its website all LHD CHAs/CHIPs in the Service Area along with a brief description of how Contractor participated in the CHA/CHIP process. Contractor must also share findings from the CHA/CHIPs in Service Area with their Community Advisory Committees (CACs).

F. Based on participation in the CHA/CHIP process in the Service Area, Contractor must annually review and update the following in accordance with the population-level needs and the DHCS Comprehensive Quality Strategy:

1) Targeted health education materials for Members, including Member-facing outreach materials for any identified gaps in services and resources, including but not limited, to Non-Specialty Mental Health Services;

2) Cultural and linguistic and quality improvement strategies to address identified population-level health and social needs; and

3) Wellness and prevention programs.

G. Contractor's MOU with an LHD must include a requirement that Contractor coordinate with the LHD to develop a process to implement DHCS guidance regarding the PNA and PHM Strategy requirements.

H. The PNA and PHM Strategy requirements, as outlined in this Subsection, and other PHM deliverables, as described in this Contract, remain consistent with 22 CCR, sections 53876, 53851(b)(2), 53851(e), 53853(d), and 53910.5(a)(2), 28 CCR, section 1300.67.04; 42 CFR sections 438.206(c)(2), 438.330(b)(4) and 438.242(b)(2); and APL 23-021.

I. Additional operational details on the PNA and PHM Strategy are located in the PHM Policy Guide. Any future updates will also be communicated to Contractor via the PHM Policy Guide.

4.3.3 Data Integration and Exchange

In accordance with the Centers for Medicare & Medicaid Services (CMS) Interoperability and Patient Access final rule (CMS-9115-F) and applicable federal and State data exchange requirements, Contractor must integrate its PHM data by expanding its Management Information System (MIS) capabilities outlined in Exhibit A, Attachment III, Section 2.1 (*Management Information System*), as follows:

A. Integrate additional data sources in accordance with all NCQA PHM standards to ensure the ability to assess the needs and characteristics of all Members;

B. Enhance interoperability of its MIS to allow for data exchange with Health Information Technology (HIT) systems and Health Information Exchange (HIE) networks as specified by DHCS;

C. Enhance interoperability of the PHM Service, in support of population health principles, integrated care, and Care Coordination across delivery systems;

D. Provide DHCS with administrative, clinical, and other data requirements as specified by DHCS; and

E. Comply with all data sharing agreements, including data exchange policies and procedures, as defined by the California Health and Human Services Data Exchange Framework in accordance with Health and Safety Code (H&S) section 130290 and APL or other guidance.

F. Comply with the CMS Interoperability and Patient Access Final Rule set forth at CMS-9115-F.

4.3.4 Medi-Cal Connect (DHCS' PHM Service)

Contractor must use the PHM Service in accordance with all applicable federal and State laws and regulations, and in a manner specified by DHCS. Contractor must use the PHM Service, at a minimum, to:

A. Perform Risk Stratification and Segmentation (RSS) activities and Risk Tiering functions as described in this Subsection;

B. Identify and assess Member-level risks and needs through use of the PHM Service's Risk Tiering functionality, which places Members into high, medium-rising, or low Risk Tiers, and use the RSS and Risk Tiering functionality to identify and assess Member-level risks and needs as specified in the PHM Policy Guide;

C. Inform and enable Member screening and assessment activities, including pre-populating screening and assessment tools; and

D. Support Member engagement and education activities.

4.3.5 Population Risk Stratification and Segmentation, and Risk Tiering

A. Contractor must use RSS and Risk Tiering to identify and assess Member-level risks and needs and, as needed, connect Members to services in a manner specified in the PHM Policy Guide and detailed below:

1) Consider findings from the PNA and all Members' behavioral, developmental, physical, oral health, and Long-Term Services and Supports (LTSS) needs, as well as health risks, rising-risks, and health-related social needs due to SDOH;

2) Comply with NCQA PHM standards;

3) Risk stratify and/or segment all Members at least annually and during each of the following timeframes:

a) Upon each Member's Enrollment;

b) Annually after each Member's Enrollment;

c) Upon a Significant Change in the health status or level of care of the Member; and

d) Upon the occurrence of events or new information that Contractor determines as potentially changing a Member's needs, including but not limited to, referrals for Complex Care Management (CCM), Enhanced Care Management (ECM), and Transitional Care Services.

4) Submit its processes to DHCS upon request regarding how it identifies Significant Changes in Members' health status or level of care and how it is monitoring appropriate re-stratification;

5) Incorporate a minimum list of data sources, as specified in the PHM Policy Guide;

6) Avoid and reduce biases in its RSS approach, such as only using utilization data, by using evidence-based methods to prevent further exacerbation of Health Disparities; and

7) Continuously reassess the effectiveness of the RSS methodologies and tools.

B. Once the PHM Service RSS and Risk Tiering functionality is available for use by Contractor, Contractor must use RSS and PHM Service Risk Tiers to:

1) Connect all Members, including those with rising risk, to an appropriate and available Contractor-identified level of service, including but not limited to, care management programs, Basic PHM, and Transitional Care Services; and

2) Contractor may supplement the PHM Service outputs with local data sources and methodologies.

C. Upon request, Contractor must ensure that its RSS and Risk Tiering approach is submitted to DHCS for review and approval in a form and method prescribed by DHCS.

4.3.6 Screening and Assessments

A. In accordance with 42 CFR section 438.208, Contractor must conduct an initial screening or assessment of each Member's needs within 90 days of Enrollment and share that information with DHCS, and other managed care health plans or Providers serving the Member, to prevent duplication of those activities. Contractor must make at least three attempts to contact a Member to conduct the initial screening or assessment using available modalities.

B. Contractor must conduct necessary screening and assessments to gain timely information on the health and social needs of all Members, in accordance with applicable State and federal laws and regulations, and NCQA PHM standards.

C. Contractor must abide by DHCS guidance for Member screening and assessment, including guidance for how to use the PHM Service for the screening and assessment process.

D. Contractor must monitor what percentage of required assessments are completed per the specifications above.

4.3.7 Care Management Programs

Contractor must maintain a PHM delivery infrastructure to ensure that the needs of its entire Member population are met across the continuum of care. The infrastructure must provide Members with the appropriate level of care

management through person-centered interventions based on the intensity of health and social needs and services required. The care management interventions described in this Subsection are intended for specific segments of the population that require more intensive engagement than the Basic PHM described in Exhibit A, Attachment III, Subsection 4.3.8 (*Basic Population Health Management*). Members receiving the care management services described in this Subsection must have an assigned CCM Care Manager and a Care Management Plan (CMP).

Enhanced Care Management

Enhanced Care Management (ECM) is a whole-person, interdisciplinary approach to comprehensive care management that addresses the clinical and non-clinical needs of high need and/or high-cost Members**.** ECM provides systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. This benefit is intended for the highest risk Medi-Cal managed care health plan Members who meet the Populations of Focus (POF) criteria. ECM is described in Exhibit A, Attachment III, Section 4.4 (*Enhanced Care Management*).

Complex Care Management

Complex Care Management (CCM) (which equates to “Complex Case Management” as defined by NCQA) is an approach to comprehensive care management that meets differing needs of high and medium rising-risk Members through both ongoing, chronic Care Coordination and interventions for episodic, temporary needs. The overall goal of CCM is to help Members regain optimum health or improved functional capability, in the right setting, and in a cost-effective manner. Contractor must consider CCM to be an opt-out program, i.e. Members have the right to participate or to decline to participate.

Both ECM and CCM are inclusive of Basic PHM, which Contractor must provide to all Members, at minimum. Care Managers conducting ECM or CCM must integrate all elements of Basic PHM into their ECM or CCM approach.

A. Care Management Programs

Contractor must operate and administer the following care management programs:

1) ECM as described in Exhibit A, Attachment III, Section 4.4 (*Enhanced Care Management*).

2) CCM

a) Contractor must operate and administer CCM in accordance with all NCQA CCM standards and requirements, and coordinate services for high and medium/rising-risk Members through Contractor's CCM approach. To the extent NCQA's standards are updated, Contractor must comply with most recent standards. Contractor must maintain and provide DHCS with policies and procedures that, at a minimum, include the following details regarding its CCM program:

   i. Contractor's CCM program must be designed and implemented to help Members gain or regain optimum health or improved functional capability in the right setting;

   ii. Contractor's CCM program must include comprehensive assessment of the Member's condition; determination of available benefits and resources; and development and implementation of a CMP with performance goals, monitoring and follow-up;

   iii. Contractor's CCM program must have an opt-out method under which Members meeting criteria for CCM have the right to decline to participate;

   iv. Contractor's CCM program must include a variety of interventions for Members that meet the differing needs of high and medium/rising-risk populations, including longer-term chronic Care Coordination and interventions for episodic, temporary needs;

   v. Contractor's CCM program must incorporate disease-specific management programs (including, but not limited to, asthma and diabetes) that include self-management support and health education;

   vi. For Members under age 21, Contractor's CCM program must include Early Periodic Screening, Diagnosis and Testing (EPSDT); all Medically Necessary services, including those that are not necessarily covered for adult Members, must be provided as long as they could be Medi-Cal-services.

b) Contractor must assess Members for the need for Community Supports as part of its CCM program to eligible Members.

c) A description of the CCM program must be included, in a manner to be prescribed by DHCS, in Contractor's annual PHMS for DHCS review and approval, outlining all the components of its CCM program, including all those listed in this Subsection.

B. CCM Care Manager Role

1) Assignment of CCM Care Manager

a) Contractor must identify and assign a CCM Care Manager for every Member receiving CCM. Following NCQA requirements, Contractor may delegate CCM to Network Providers or other entities that are NCQA-certified. PCPs may be assigned as CCM Care Managers when they are able to meet all the requirements specified in this Subsection.

b) When a CCM Care Manager other than the Member's PCP is assigned, Contractor must provide the Member's PCP with the identity of the Member's assigned CCM Care Manager, and a copy of the Member's CMP.

c) When multiple Providers perform separate aspects of Care Coordination for a Member, Contractor must:

i. Identify a lead CCM Care Manager and communicate the identity of the Care Manager to all treating Providers and the Member; and

ii. Maintain policies and procedures to ensure compliance and non-duplication of Medically Necessary services and delegation of responsibilities between Contractor and the Member's Providers in meeting all care management requirements.

2) CCM Care Manager Responsibilities

a) Contractor is responsible for ensuring CCM Care Managers comply with all of the Basic PHM requirements in Exhibit A, Attachment III, Subsection 4.3.8 (*Basic Population Health Management*) and all NCQA CCM standards.

b) Contractor must ensure that the CCM Care Manager performs the following duties:

i. Conduct Member assessments as needed to identify and close any gaps in care and address the Member's physical, mental health, Substance Use Disorder (SUD), developmental, oral health, dementia, palliative care, chronic disease, and LTSS needs as well as needs due to SDOH;

ii. Complete a CMP for all Members receiving CCM, consistent with the Member's goals in consultation with the Member. The CMP must:

a. Address a Member's health and social needs, including needs due to SDOH;

b. Be reviewed and updated at least annually, upon a change in Member's condition or level of care, or upon request of the Member;

c. Be in an electronic format and a part of the Member's Medical Record, and document all of the Member's services and treating Providers;

d. Be developed using a person-centered planning process that includes identifying, educating, and training the Member's parents, family members, legal guardians, Authorized Representatives (Ars), caregivers, or authorized support persons, as needed; and

e. Include referrals to community-based social services and other resources even if they are not Covered Services under this Contract.

iii. Ensure continuous information sharing and communication with the Member and their treating Providers; and

iv. Specify the responsibility of each Provider that provides services to the Member.

c) Ensure Members receive all Medically Necessary services, including Community Supports, to close any gaps in care

and address the Member's mental health, SUD, developmental, physical, oral health, dementia, palliative care needs as well as needs due to SDOH;

d) Support and assist the Member in accessing all needed services and resources, including across the physical and Behavioral Health delivery systems;

e) Communicate to Members' parents, family members, legal guardians, Ars, caregivers, or authorized support persons all Care Coordination provided to Members, as appropriate;

f) Provide referrals to Community Health Workers (CHWs), peer counselors, and other community-based social services including, but not limited to, personal care services, LTSS, Community Supports and local community organizations and other programs or services offered by other agencies and third-party entities with which Contractor has or will have a MOU;

g) Assess the Member's understanding of the referral instructions and follow-up to determine whether the referral instructions were completed or whether the Member needs further assistance to access the services, and if so, provide such assistance;

h) Review and/or modification of Member's CMP, when applicable, to address unmet service needs;

i) Facilitate and encourage the Member's adherence to recommended interventions and treatment; and

j) Ensure timely authorization of services to meet the Member's needs in accordance with the Member's CMP.

4.3.8 Basic Population Health Management

A. Contractor must provide Basic PHM to all Members, in accordance with 42 CFR section 438.208. Contractor must maintain policies and procedures that meet the following Basic PHM requirements, at a minimum:

1) Ensure that each Member has an ongoing source of care that is appropriate, ongoing and timely to meet the Member's needs;

2) Ensure Members have access to needed services including Care Coordination, navigation and referrals to services that address

Members' developmental, physical, mental health, SUD, dementia, LTSS, palliative care, and oral health needs;

3) Ensure that each Member is engaged with their assigned PCP and that the Member's assigned PCP plays a key role in the Care Coordination functions described in this Subsection, in partnership with Contractor;

4) Ensure each Member receives all needed preventive services in partnership with the Member's assigned PCP;

5) Ensure efficient Care Coordination and continuity of care for Members who may need or are receiving services and/or programs from out-of-Network Providers;

6) Ensure Members are provided with resources and education about how to access the various programs and services offered by agencies and third-party entities with whom Contractor has or will have an executed MOU;

7) Review Member utilization reports to identify Members not using Primary Care; stratify such reports, at minimum, by race and ethnicity to identify Health Disparities that result from differences in utilization of outpatient and preventive services; and develop strategies to address differences in utilization;

8) Facilitate access to care for Members by, at a minimum, helping to make appointments, arranging transportation, ensuring Member health education on the importance of Primary Care for Members who have not had any contact with their assigned Medical Home/PCP or have not been seen within the last 12 months, particularly Members less than 21 years of age;

9) Ensure all services are delivered in a culturally and linguistically competent manner that promotes Health Equity for all Members;

10) Coordinate health and social services between settings of care, across other Medi-Cal managed care health plans, delivery systems, and programs (e.g., Targeted Case Management, Specialty Mental Health Services), with external entities outside of Contractor's Network, and with Community Supports and other community-based resources, even if they are not Covered Services under this Contract, to address Members' needs and to mitigate impacts of SDOH;

11) Coordinate referrals to ensure Care Coordination with public benefits programs, including without limitation, as required by this Contract under the requirements set forth for Memorandums of Understanding (MOUs) in Exhibit A, Attachment III, Section 5.6 (*MOUs with Local Government Agencies, County Programs, and Third Parties*);

12) Ensure referrals initiated on behalf of Members for services or supports subject to Closed-Loop Referral (CLR) requirements are tracked, supported, and monitored and result in a Known Closure which aligns with DHCS CLR Implementation Guidance. Contractor must establish procedures and adhere to all DHCS CLR requirements as outlined in the PHM Policy Guide, APL 22-024, and DHCS CLR Implementation Guidance.

13) Assist Members, Members' parents, family members, legal guardians, ARs, caregivers, or authorized support persons with navigating health delivery systems, including Contractor's Subcontractor and Downstream Subcontractor Networks, to access Covered Services as well as services not covered under this Contract;

14) Provide Members with resources to address the progression of disease or disability, and improve behavioral, developmental, physical, and oral health outcomes;

15) Communicate to Members' parents, family members, legal guardians, ARs, caregivers, or authorized support persons all Care Coordination provided to Members, as appropriate;

16) Ensure that Providers furnishing services to Members maintain and share, as appropriate, Members' Medical Records in accordance with professional standards and State and federal law;

17) Facilitate exchange of necessary Member Information in accordance with any and all State and federal privacy laws and regulations, including data exchange policies and procedures, as defined by the California Health and Human Services Data Exchange Framework in accordance with H&S section 130290 and APL or other guidance, specifically pursuant to 45 CFR parts 160 and 164 subparts A and E, to the extent applicable; and

18) Maintain processes to ensure no duplication of services occurs.

B. Wellness and Prevention Programs

1) Contractor must provide wellness and prevention programs that meet NCQA PHM standards, including for the provision of evidence-based self-management tools;

2) Contractor must ensure that the wellness and prevention programs align with the DHCS Comprehensive Quality Strategy;

3) Contractor must provide wellness and prevention programs in a manner specified by DHCS, and in collaboration with LGAs as appropriate, that include the following, at a minimum:

    a) Identification of specific, proactive wellness initiatives and programs that address Member needs;

    b) Evidence-based disease management programs including, but not limited to, programs for diabetes, cardiovascular disease, asthma, and depression that incorporate health education interventions, target Members for engagement, and seek to close care gaps for Members participating in these programs;

    c) Initiatives, programs, and evidence-based approaches to improving access to preventative health visits, developmental screenings and services for Members less than 21 years of age, as described in Exhibit A, Attachment III, Subsection 5.3.4 (*Services for Members Less Than 21 Years of Age*);

    d) Initiatives, programs, and evidence-based approaches on improving pregnancy outcomes for women, including through 12 months post-partum;

    e) Initiatives, programs, and evidence-based approaches on ensuring adults have access to Preventive Care, as described in Exhibit A, Attachment III, Subsection 5.3.5 (*Services for Adults*) and in compliance with all applicable State and federal laws;

    f) A process for monitoring the provision of wellness and preventive services by PCPs as part of Contractor's Site Review process, as described in Exhibit A, Attachment III, Subsection 5.2.14 (*Site Review*);

    g) Health education materials, in a manner that meets Members' health education and cultural and linguistic needs,

in accordance with Exhibit A, Attachment III, Subsection 5.3.7 (*Services for All Members*); and

h) Initiatives and programs that implement evidence-based best practices that are aimed at helping Members set and achieve wellness goals.

4) Contractor must ensure that its wellness and prevention programs are submitted to DHCS for review and approval in a form and method prescribed by DHCS.

5) Contract must report annually through the PHMS on how community-specific information and stakeholder input from the PNA is used to design and implement evidence-based wellness and prevention strategies.

4.3.9 Other Population Health Requirements for Children

For Members less than 21 years of age, Contractor must provide as part of care management and Basic PHM the following services for Children:

A. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Case Management Responsibilities

Contractor must provide case management to assist Members less than 21 years of age in gaining access to all Medical Necessary medical, Behavioral Health, dental, social, educational, and other services, as defined in 42 United States Code (USC) sections 1396d(a), 1396d(r), and 1396n(g)(2), and Welfare and Institutions Code (W&I) section 14059.5(b). Case management services for Members less than 21 years of age also include the data exchange necessary for the provision of services as well as the coordination of non-covered services such as social support services. Additionally, Contractor must provide EPSDT case management services as Medically Necessary services for Members less than 21 years of age, as required in Exhibit A, Attachment III, Subsection 5.3.4 (*Services for Members Less Than 21 Years of Age*), and must ensure that all Medically Necessary services for Members less than 21 years of age are initiated within timely access standards whether or not the services are Covered Services under this Contract.

B. Children and Youth with Special Health Care Needs

Contractor must develop and implement policies and procedures to provide services for CYSHCN. Contractor must ensure that the policies and procedures include the following information, at a minimum, to encourage CYSHCN Member participation:

1) Methods for ensuring and monitoring timely access to pediatric Specialists, sub-Specialists, ancillary therapists, transportation, and Durable Medical Equipment (DME) and supplies. These may include assignment to a Specialist as PCP, Standing Referrals, or other methods.

2) Methods for monitoring and improving the quality, Health Equity and appropriateness of care for CYSHCN.

3) Methods for ensuring Care Coordination with Department of Developmental Services (DDS), local health departments and local California Children's Services (CCS) Programs, as appropriate and as required under any applicable MOUs between Contractor and local health departments and DDS for the County CCS Program.

C. Early Intervention Services

Contractor must develop and implement systems to identify Members who may be eligible to receive services from the Early Start program and refer them to the local Early Start program. These Members include those with a condition known to lead to developmental delay, those in whom a developmental delay is suspected, or whose early health history places them at risk for delay. Contractor must collaborate with the local RC or local Early Start program in determining the Medically Necessary diagnostic and preventive services and treatment plans for Members. Contractor must provide case management and Care Coordination to the Member to ensure the provision of all Medically Necessary Covered Services identified in the Individualized Family Service Plan (IFSP) developed by the Early Start program, with PCP participation.

4.3.10 Transitional Care Services

Contractor must provide Transitional Care Services (TCS) to all Members transferring from one setting, or level of care, to another in accordance with 42 CFR section 438.208, other applicable federal and State laws and regulations, APL 22-024, and the PHM Policy Guide. Transferring from one setting, or level of care, to another includes, but is not limited to, discharges from hospitals, institutions, acute care facilities, and Skilled Nursing Facilities (SNFs) to home or community-based settings, Community Supports, post-acute care facilities, or Long-Term Care (LTC) settings.

Contractor must identify every Member undergoing a transition as high-risk or lower-risk according to the criteria in the PHM Policy Guide.

For all identified high-risk Members, Contractor must ensure a Member has a

single point of contact for the duration of the transition. If a Member identified as high risk is not receiving CCM or ECM, Contractor must identify a care manager who is a single point of contact responsible for ensuring the completion of all Transitional Care Services, including making referrals and ensuring no gaps in care. For Members identified as lower risk, a single point of contact is not required, but there must be a dedicated care management team available, as described further in the PHM Policy Guide.

Contractor must ensure that TCS processes meet the requirements of A-C below, for both high and lower risk Members. The PHM Policy Guide describes in further detail how the requirements below apply to high and lower risk Members.

Additional guidance is forthcoming on the specific TCS requirements for different populations.

A. General Requirements for Transitional Care Applicable to All Members in Transition, including High- and Lower-Risk Members

Contractor must implement transitional care processes that meet the following further requirements as specified in the PHM Policy Guide, at minimum:

1) Ensure each Member is evaluated for all care settings appropriate to the Member's condition, needs, preferences and circumstances. Members must not be discharged to a setting that does not meet their medical and/or LTSS needs;

2) Ensure that permission is obtained from Members, Members' parents, legal guardians, or ARs, as appropriate to share information with Providers to facilitate transitions, in accordance with federal and State privacy laws and regulations;

3) Ensure referrals to Community Supports and coordination with county social service agencies and waiver agencies for In-Home Supportive Services (IHSS) and other Home and Community-Based Services (HCBS) for Members who may be eligible for such services, and as applicable, in accordance with any MOU executed between Contractor and such agencies;

4) Ensure referrals to ECM and Community Supports for Members identified as having unstable housing, experiencing homelessness, or needing nursing facility care, for whom transition to home/assisted living facility or short-term post hospitalization/recuperative care are alternatives;

5) Ensure all Prior Authorizations required for the Member's discharge

are processed within timeframes consistent with the urgency of the Member's condition, not to exceed five Working Days for routine authorizations, or 72 hours for expedited authorizations, in accordance with Exhibit A, Attachment III, Subsection 2.3.2 (*Timeframes for Medical Authorization*). Prior Authorizations should be complete prior to discharge. This includes Prior Authorizations for therapy, home care, medical supplies, prescription medications for which Contractor is responsible, and DME that are processed in accordance with 42 CFR section 438.210, H&S section 1367.01, and Exhibit A, Attachment III, Section 2.3 (*Utilization Management Program*) of this Contract;

6) Ensure all Network Provider hospitals, institutions, and facilities educate their Discharge Planning staff on the services, supplies, medications, and DME needing Prior Authorization;

7) Ensure that mutually agreed-upon policies and procedures for Discharge Planning and Transitional Care Services exist between Contractor and each of its Network Provider and out-of-Network Provider hospitals within its Service Area;

8) Prevent delayed discharges of a Member from a hospital, institution, or facility due to circumstances such as, but not limited to, Contractor authorization procedures or transitions to a lower level of care, by determining and addressing the root causes of why delays occur;

9) Require all of its contracted hospitals, and all SNFs with electronic health records, to send Admission, Discharge, and Transfer (ADT) notifications to Contractor for each of its assigned Members in accordance with the Interoperability and Patient Access Final Rule set forth at CMS-9115-F, and in accordance with the California Health and Human Services Data Exchange Framework set forth in H&S section 130290, APL or other guidance, and as further specified in the PHM Policy Guide; and

10) Ensure all Members being discharged from discharging facilities, including SNFs, have a PCP who can provide follow-up care, as appropriate, and that the discharging facilities have contact information for PCPs.

B. Responsibility to Ensure Completion of Facility’s Discharge Planning Process, Including Member Engagement for All Members, Including Both High and Lower Risk Members.

Contractor must ensure the discharging facility completes a Discharge Planning process that engages Members, Members' parents, legal guardians, or Authorized Representatives, as appropriate, when being discharged from a hospital, institution or facility. Contractor must ensure that the facility's process is consistent with CMS Conditions of Participation, State regulations, and Joint Commission Requirements, as applicable, including as follows:

1) Contractor must ensure the discharging facility focuses on the Member's goals and treatment preferences during the discharge process, and that they are documented in the Medical Record. Contractor must ensure the discharging facility uses a consistent assessment process and/or assessment tools to identify Members who are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning.

    a) For high-risk Members, Contractor must ensure the facility shares this information with the care manager. Contractor must also ensure the discharging facility has processes and procedures in place to refer Members to ECM or Community Supports as needed.

    b) For lower risk Members, Contractor must ensure the hospital has processes and procedures to leverage this assessment to identify Members who may benefit from services and refer Members to Contractor for high risk TCS, ECM, or Community Supports.

2) For discharge instructions, Contractor must ensure that the Member and their designated caregiver are informed of the continuing health care requirements following discharge from the facility. This information must include, but is not limited to, education and counseling about the Member's medications, including dosing and proper use of medication delivery devices, when applicable. The information must be provided in a culturally and linguistically appropriate format to the Member and caregiver, and must include the opportunity for the caregiver to ask questions about the post-hospital needs of the Member per H & S section 1262.5.

3) For discharge coordination, Contractor must ensure discharging facility has process in place for coordinating care with the following:

    a) For Member's designated family caregiver, Contractor must ensure the discharging facility has processes to ensure Member's designated family caregiver is notified of the

Member's discharge or transfer to another facility per H&S section 1262.5.

b) For post-discharge Providers, Contractor must ensure discharging facility provides necessary clinical information to the appropriate post-discharge Providers, including the discharge summary per 42 CFR section 482.43.

C. Transitional Care Services for High and Lower Risk Members

1) Contractor must identify every Member undergoing a transition as high risk or lower-risk. For the criteria for high and lower-risk, and detailed requirements for each, refer to the PHM Policy Guide.

2) For Members identified as high risk, Contractor must ensure the Member has a single point of contact for the duration of the transition who is responsible for ensuring a successful transition. If the Member is receiving CCM or ECM, Contractor must ensure that the Member's assigned care manager provides all TCS. The single point of contact is responsible for:

a) Outreach to Member;

b) Assessing Member's risk for adverse outcomes to inform needed TCS and identify Members that may require ECM, CCM (if not already enrolled), or Community Supports, using the discharging facility data and Member engagement;

c) Reviewing facility discharge summary;

d) Ensuring Member receives appropriate discharge instructions;

e) Ensuring follow up Providers receive appropriate clinical information;

f) Ensuring medication reconciliation is complete post discharge;

g) Ensuring Members with SUD and mental health needs receive treatment for those conditions upon discharge; and

h) Ensuring the completion of all recommended follow-up, including any needed specialty or primary care follow-up, any SUD or mental health treatment, or any needed community or home-based services.

3) For Members identified as lower risk, Contractor must, in addition to meeting all general requirements in Paragraphs A and B above:

a) Ensure Member has, at minimum, telephonic access to a dedicated TCS team for at least 30 days from the discharge. The team must:

i. Be able to access the Member's discharge documents to be able to assist Member with questions, including but not limited to medication changes;

ii. Assist Member with any TCS needs identified by Member, including but not limited to access to ambulatory care, appointment scheduling, referrals, arranging Non-Emergency Medical Transport (NEMT);

iii. Provide escalation to meet any TCS needs as needed, including connecting Members with a licensed Provider, if necessary; and

iv. Place and coordinate referrals to longer term care management programs such as ECM/CCM, and/or Community Supports for eligible Members at any point in the transition.

b) Ensure Member can access the TCS team through a dedicated phone number as follows:

i. During business hours, Contractor must ensure Members can connect with live TCS team member within no more than one automated phone selection option.

ii. Outside of business hours, Members must be able to be referred to Emergency Services as needed and be able to leave a message. TCS team must respond to Members within one Working Day of message.

iii. Contractor must ensure the Member is notified of the TCS support team and phone line directly, and make best efforts to ensure Member is notified directly within 24 hours of discharge.

c) Ensure Member completes follow-up with ambulatory PCP, Specialist, or advanced practice Provider that has prescribing authority within 30 calendar days to ensure medication reconciliation. For a Member who has not had a visit with their assigned PCP within the last 12 months, ensure the Member completes PCP follow-up in addition to any necessary non-primary care ambulatory visits within 30 calendar days.

d) Use data from discharges to assess and identify Members that may newly qualify for ECM/CCM or Community Supports.

D. Nursing Facility Transitions

1) For diversion from the need for a nursing facility with supports, Contractor must evaluate all Members who have been identified as requiring nursing facility care for Community Supports. This includes the following, as appropriate: short-term post-hospitalization housing, recuperative care (medical respite), respite services, day habilitation programs, community or home transition services; assisted living facility transitions; and homemaker services, and ECM, IHSS, and/or waiver programs that may allow the Member to live at home or in alternative settings with support, as aligned with the Member's goals.

2) When transitioning Members to and from SNFs, Contractor must comply with APL 23-004. Contractor must ensure timely Member transitions that do not delay or interrupt any Medically Necessary services or care by meeting the following requirements, at a minimum:

a) Coordinate with facility discharge planners, care or Case Managers, or social workers to provide case management and Transitional Care Services during all transitions;

b) Assist Members being discharged or Members' parents, legal guardians, or ARs by evaluating all medical needs and care settings available including, but not limited to, discharge to a home or community setting, and referrals and coordination with IHSS, Community Supports, LTSS, and other HCBS programs;

c) Maintain contractual requirements for SNFs to share Minimum Data Set (MDS) Section Q, have appropriate systems to import and store MDS Section Q data and

incorporate MDS Section Q data into transition assessments;

d) Ensure all Members being discharged from nursing facilities, have a PCP that can provide follow-up care, as appropriate, and that the discharging facilities have contact information for PCPs;

e) Ensure Member outpatient appointment(s) or other immediate follow-ups are scheduled prior to discharge;

f) Verify with facilities or at-home settings that Members arrive safely at the agreed upon care setting and have their medical needs met; and

g) Follow-up with Members, Members' parents, legal guardians, or ARs, as appropriate, regarding the new care setting to ensure compliance with Transitional Care Services requirements.

4.3.11 Targeted Case Management Services

A. Contractor must identify the target populations for Targeted Case Management (TCM) programs within their Service Area, and maintain procedures to refer Members to TCM services. If upon notification from DHCS that Members are receiving TCM services Contractor is not already aware of, Contractor must reach out to LGAs to coordinate care, as appropriate.

B. Contractor must coordinate with LGAs to provide Care Coordination for all Medically Necessary Covered Services identified by TCM Providers in their Member care plans, including referrals and Prior Authorization for out-of-Network medical services. Coordination with LGAs must continue for Members receiving TCM services until the LGA notifies Contractor that TCM services are no longer needed for the Member.

C. Because TCM can be a direct duplication of services such as, but not limited to, Basic PHM, CCM, ECM, and Community Supports, Contractor must have processes to ensure Members receiving TCM are not receiving duplicative services. For specific guidance on ECM overlap with county-based TCM, see the ECM Policy Guide.

D. Contractor must designate a representative responsible for coordinating TCM services with LGAs for the Member. Contractor representative's responsibilities include, but are not limited to, sharing the appropriate

Member Provider(s) information and PCP and/or Care Manager assignment with LGAs and resolving all related operational issues.

E. Contractor must also notify Members' PCPs and/or Care Managers when Members are receiving TCM services and provide them with the appropriate LGA contact information.

F. For Members less than 21 years of age, Contractor must ensure that all Medically Necessary services are provided timely as required in Exhibit A, Attachment III, Subsection 5.3.4 (*Services for Members Less Than 21 Years of Age*). Notwithstanding medical services recommended in TCM care plans or arranged by LGAs or TCM Providers for Members less than 21 years of age, Contractor remains responsible for the provision of the EPSDT benefit, as described in Exhibit A, Attachment III, Section 5.3 (*Scope of Services*).

4.3.12 Mental Health Services

A. Contractor must use DHCS-approved standardized screening tools as identified in APL 25-010 to ensure Members seeking mental health services who are not currently receiving Non-Specialty Mental Health Services (NSMHS) or Specialty Mental Health Services (SMHS) receive referrals to the appropriate delivery system for mental health services, either in Contractor's Network or the Mental Health Plan (MHP) network, in accordance with the No Wrong Door policies set forth in W&I section 14184.402(f) and specified in Exhibit A, Attachment III, Section 5.5 (*Mental Health and Substance Use Disorder Benefits*).

1) Non-Specialty Mental Health Services

a) Contractor must provide timely NSMHS for Members consistent with the No Wrong Door policies even when:

i. NSMHS were provided:

a. During the assessment process;

b. Prior to determination of a diagnosis; or

c. Prior to determination of whether NSMHS criteria set forth in W&I section 14184.402(b)(2) are met;

ii. NSMHS were not included in a Member's individual treatment plan;

iii. Member has a co-occurring mental health condition and SUD; or

iv. NSMHS are provided to a Member concurrently with SMHS, if those services are not duplicative and coordinated between Contractor and the MHP.

2) Specialty Mental Health Services

a) Contractor must maintain policies and procedures to refer Members who meet the criteria for SMHS to the MHP in accordance with the No Wrong Door policies.

b) Contractor must also enter into a MOU with the MHP in accordance with Exhibit A, Attachment III, Subsection 5.6.1 (*MOU Purpose*) to ensure services for its Members are properly coordinated and provided in a timely and non-duplicative manner.

c) If a Member receiving NSMHS is determined to meet the criteria for SMHS due to a change in the Member's condition, Contractor must use DHCS-approved standardized transition tools in accordance with Exhibit A, Attachment III, Subsection 5.5.2 (*Non-Specialty Mental Health Services and Substance Use Disorder Services*), and continue to provide NSMHS to the Member concurrently receiving SMHS when those services are not duplicative and coordinated between Contractor and the MHP.

3) Mental Health Services Disputes

a) Disputes between Contractor and MHP must not delay the provision of Medically Necessary services by Contractor or MHP.

b) If Contractor and MHP cannot agree on the appropriate place of care, disputes must be resolved pursuant to APL 21-013, and as specified in Exhibit A, Attachment III, Subsection 5.5.5 (*Mental Health and Substance Use Disorder Services Disputes*). Specifically, as set forth in APL 21-013, Contractor and MHPs must complete the plan level dispute resolution process within 15 Working Days of identifying the dispute.

c) Contractor and MHP may seek to enter into an expedited dispute resolution process if a Member has not received a

disputed service(s) and Contractor and/or MHP determine that the routine dispute resolution process timeframe would result in serious jeopardy to the Member's life, health, or ability to attain, maintain, or regain maximum function. Under this expedited process, Contractor and MHP will have one Working Day after identification of a dispute to attempt to resolve the dispute at the plan level. All terms and requirements established in APL 21-013 apply to disputes between Contractor and MHP.

B. Contractor must create and update annually both a Member and Primary Care Provider (PCP) Non-Specialty Mental Health Services (NSMHS) Outreach and Education Plan, as specified by APL 24-012. Contractor must publicly post on their website the DHCS approved NSMHS outreach and education plans and utilization assessment annually.

4.3.13 Alcohol and Substance Use Disorder Treatment Services

A. Contractor must identify and refer Members requiring alcohol and/or SUD treatment services to the County Department responsible for alcohol and SUD treatment, other community resources when services are not available through the County Department, or to outpatient heroin and other opioid detoxification Providers available through the Medi-Cal Fee-For-Service (FFS), as appropriate. Contractor must assist Members in locating available treatment service sites. To the extent that alcohol and/or SUD treatment services are not available within Contractor's Service Area, Contractor must coordinate with the County Department responsible for SUD treatment to refer Members to available treatment outside of Contractor's Service Area.

B. Contractor must have MOUs with each County Department responsible for alcohol and SUD treatment services within Contractor's Service Area in accordance with the MOU requirements in Exhibit A, Attachment III, Section 5.6 (*MOUs with Local Government Agencies, County Programs, and Third Parties*). The MOU must delineate the roles and responsibilities between Contractor and County Departments for coordinating care, and ensuring non-duplication of services and timeliness of care for the Members.

C. For Members receiving alcohol and SUD treatment services through County Departments, Contractor must continue to provide all Medically Necessary Covered Services and coordination and referral of services between its Network Providers and other treatment programs for the Member.

D. Prescribing and medication management of buprenorphine and other prescribed medications for SUD treatment (also known as medication-assisted treatment or MAT) are the responsibility of Contractor when they are provided in Primary Care offices, departments, hospitals, or other contracted medical facilities.

E. Contractor must enter into a data sharing agreement with the County Department responsible for alcohol and SUD treatment, other community resources when services are not available through the County Department, or to outpatient opioid disorder treatment. Contractor's data sharing agreement with such County Departments must also require such County Departments, and all Part 2 programs contracting with such County Departments that provide services to Members, to use authorization forms that align with DHCS data sharing and authorization guidance for the disclosure of information that
provide the following:

1) Comply with 42 CFR part 2;

2) Name both Contractor and DHCS as potential recipients of the data being disclosed;

3) Indicate that Contractor and DHCS are permitted to use such data for payment and health care operations purposes, as defined by HIPAA; and

4) If 42 CFR Part 2 is modified to permit such a practice, include a statement indicating that any information disclosed to a covered entity or business associate may be redisclosed to the extent permitted by the HIPAA privacy rule, except for uses and disclosures for civil, criminal, administrative, and legislative proceedings against the patient.

4.3.14 California Children's Services

A. Notwithstanding any other provisions in W&I section 14094.4 *et seq*. for Contractors operating in COHS counties, Contractor must maintain policies and procedures to identify and refer Members with a potential California Children's Services (CCS)-Eligible Condition to the County CCS Program for determination of CCS eligibility and the Medical Therapy Program (MTP). These policies and procedures must include the following, at a minimum:

1) The requirement that Network Providers complete the appropriate baseline health assessments and diagnostic evaluations, which

provide sufficient clinical detail to establish, or raise a reasonable suspicion, that a Member has a potential CCS-Eligible Condition.

2) The requirement that Contractor supports County CCS Program referral pathways in the non-Whole Child Model counties including but not limited to identifying children who may be eligible for the CCS Program through internal reports, Provider directed referrals, or direct referrals from Contractor.

3) Contractor must provide training for Network Providers, Subcontractors, and Downstream Subcontractors. The training must include information on CCS and MTP, how to refer Members to CCS and MTP, and how to assist Members with accessing CCS and MTP services. The training must include:

   a) Instructions on how to complete the appropriate baseline health assessments and diagnostic evaluations, which provide sufficient clinical detail to establish or raise a reasonable suspicion that a Member has a CCS-Eligible/MTP-Eligible Condition;

   b) Instructions on how to refer Members with a suspected CCS-Eligible/MTP-Eligible Condition on the same day the evaluation is completed, using methods accepted by the County CCS Program. A separate referral must be submitted for each suspected CCS-Eligible/MTP-Eligible Condition. The initial referral must include the submission of supporting medical documentation sufficient to allow for a CCS Program eligibility determination by the CCS Program;

   c) Instructions that the CCS Program reimburses only CCS paneled Providers and CCS approved hospitals within Contractor’s Network, and that reimbursement is only from the date of completed referral;

   d) Instructions that Network Providers must continue to provide all Medically Necessary Covered Services to the Member until the Member’s CCS Program eligibility is confirmed;

   e) Information on how to refer Members in CCS and MTP to community resources; and

   f) Information on how Network Providers can assist with accessing CCS Program authorized services and can coordinate such services with other services Members may receive.

4) The requirement that once eligibility for the CCS Program is established for a Member, Contractor must continue to provide all Covered Services that are not authorized by the County CCS Program and must ensure the coordination of services and joint case management between the Member's PCP, CCS Providers, and the County CCS Program. Contractor must continue to provide case management services to ensure all Covered Services authorized through the CCS Program are provided timely as required in Exhibit A, Attachment III, Subsection 5.3.4 (*Services for Members Less Than 21 Years of Age*). Without limitation, Contractor must, as necessary, including upon a Member's request, arrange for all in-home nursing hours authorized by the CCS Program that a Member desires to utilize, as required by APL 20-012. Contractor must provide to the County CCS Program, in a timely manner, all medical utilization; and other clinical data necessary for the County CCS Program to make initial eligibility determinations, conduct annual medical reviews, and perform other medical reviews, as needed, for CCS-eligible Members. Contractor must notify the County CCS Program when Contractor becomes aware that a CCS-eligible Member has passed away.

5) The requirement that Contractor ensure all Medically Necessary Covered Services are provided to the Member if the CCS Program does not approve CCS Program eligibility. If the CCS Program denies authorization for any service, Contractor remains responsible for providing and reimbursing for the cost of the service if it is determined to be Medically Necessary.

B. Authorization for payment must be retroactive to the date the CCS Program was informed about the Member through an initial referral by Contractor or a Network Provider. In an emergency admission, Contractor or a Network Provider must be allowed until the next Working Day to inform the County CCS Program about the Member.

C. Contractor must maintain policies and procedures for identifying CCS-eligible Members that are transitioning out of CCS and MTP. Within 12 months of a CCS/MTP Member transitioning out of the program, Contractor must develop a Care Coordination plan to assist the Member in transitioning out of the CCS Program. The policies and procedures must include, the following, at a minimum:

1) At age 17 years, Contractor shall collaborate with the County CCS Program to begin developing a transition plan for CCS members and share the transition plan with the PCP to include:

a) The identified adult specialist, medical group, or medical home; and

b) Authorized Representative/legal guardian (if needed).

2) At age 20 years, Contractor shall collaborate with the County CCS Program to develop and finalize the exit summary for the transition plan for all CCS members. The exit summary shall be shared with the CCS member, the Authorized Representative/guardian (if needed) and the PCP, and shall include:

a) The identified adult specialist, medical group, or medical home; and

b) Authorized Representative/legal guardian (if needed).

3) Identifying the Member's CCS-Eligible Condition; and any other programs the Member may be eligible for based upon their CCS eligible condition;

4) Planning for the needs of the Member to transition from the CCS Program;

5) A communication plan with the Member in advance of the transition;

6) Identification and coordination of Primary Care and specialty care Providers appropriate to the Member's CCS-Eligible Condition(s); and

7) Continued assessment of the Member through first 12 months of the transition.

D. Contractor must have Memorandums of Understanding (MOUs) with each CCS Program within its Service Area that are in accordance with the MOU requirements in Exhibit A, Attachment III, Section 5.6 (*MOUs with Local Government Agencies, County Programs, and Third Parties*). The MOU must delineate the roles and responsibilities of Contractor and the County CCS Program for coordinating care and ensuring the non-duplication of services.

4.3.15 Services for Persons with Developmental Disabilities

A. Contractor must maintain policies and procedures for identifying and tracking Members with Developmental Disabilities (DD), including all services they receive.

B. Contractor must designate its own liaison to coordinate with each RC operating within Contractor's Service Area to assist Members with DD in understanding and accessing services, and to act as a central point of contact for questions, access and care concerns, and problem resolution, as required by W&I section 14182(c)(10).

C. Contractor must refer Members with DD to a RC for evaluation and for access to non-medical services provided by the RC, including, but not limited to, respite, out-of-home placement, and supportive living. Contractor must have an MOU in place as required in Exhibit A, Attachment III, Section 5.6 (*MOUs with Local Government Agencies, County Programs, and Third Parties*) to coordinate services for the Member with RC staff to ensure the non-duplication services and to create the individual developmental services plan required for all Members with DD, which includes identification of the Member's medical needs and the provision of Medically Necessary services such as medical care, NSMHS, and Behavioral Health Treatment (BHT).

D. Contractor must maintain policies and procedures to identify and refer eligible Members to the HCBS program administered by the Department of Developmental Services (DDS).

E. Contractor must refer to Exhibit A, Attachment III, Subsection 4.3.20 (*Home and Community-Based Services Programs*) for further coordination of care requirements related to providing HCBS programs through the HCBS-DD Waiver.

4.3.16 School-Based Services

A. Contractor must negotiate in good faith and execute MOUs with all LEAs and/or County Offices of Education, as applicable, if agreed to by all stakeholders involved, in its Service Area in accordance with Exhibit A, Attachment III, Section 5.6 (*MOUs with Third Parties*) to ensure there are processes that account for facilitating cooperation and collaboration between the Member's PCP and the LEA in the development of the Member's Individualized Education Plan (IEP) or the IFSP. Contractor must provide case management and Care Coordination to the Member, or the parent, legal guardian, or AR, to ensure the provision of all Medically Necessary Covered Services identified in the IEP developed by the LEA, with PCP participation.

B. Contractor must cover Medically Necessary mental health and SUD services as specified by DHCS when delivered by school-linked behavioral health providers to a Member who is 25 years of age or younger. Contractor must cover these services in accordance with DHCS

guidance related to the Children and Youth Behavioral Initiative (CYBHI) and at the DHCS established fee schedule Contractor must execute agreements in accordance with DHCS guidance and in accordance with H&S section 1374.722 and W&I section 5963.4(c).

C. By 2025, Contractor is required to provide Covered Services, including preventive services and adolescent health services provided in schools or by school-affiliated health providers.

D. Contractor must implement interventions that increase access to preventive, early intervention, and Behavioral Health Services by school-affiliated Behavioral Health Providers for Children in publicly funded childcare and preschool, and TK-12 Children in public schools, in accordance with the interventions, goals, and metrics set forth in W&I section 5961.3(b).

4.3.17 Dental

A. Contractor must cover and ensure that dental screenings and oral health assessments are included for all Members. Contractor must ensure that all Members are given referrals to appropriate Medi-Cal dental Providers. Contractor must provide Medically Necessary Federally Required Adult Dental Services (FRADS), fluoride varnish, and dental services that may be performed by a medical professional. Dental services that are exclusively provided by dental Providers are not covered under this Contract.

B. For Members less than 21 years of age, Contractor must ensure that a dental screening and an oral health assessment are performed as part of every periodic assessment, with annual dental referrals beginning with the eruption of the Member's first tooth or at 12 months of age, whichever occurs first.

C. Contractor must ensure the provision of Medically Necessary dental-related Covered Services that are not exclusively provided by dentists or dental anesthetists. Contractor must also have an identified Contractor liaison available to Medi-Cal dental Providers to assist with referring the Member to other Covered Services. Other Covered Services include, but are not limited to laboratory services, and pre-admission physical examinations required for admission to an outpatient surgical service center, or an in-patient hospitalization required for a dental procedure (including facility fees and anesthesia services for both inpatient and outpatient services). Contractor may require Prior Authorization for Medically Necessary Covered Services needed in support of dental procedures.

If Contractor requires Prior Authorization in support of dental procedures, Contractor must develop and publish the policies and procedures for obtaining Prior Authorization for dental services to ensure that services are provided to the Member in a timely manner. Contractor must coordinate with DHCS Medi-Cal Dental Services Division in the development of their policies and procedures pertaining to Prior Authorization for dental services and must submit such policies and procedures to DHCS for review and approval.

4.3.18 Direct Observed Therapy for Treatment of Tuberculosis

Contractor must assess the risk of treatment resistance or noncompliance with drug therapy for each Member who requires placement on anti-tuberculosis drug therapy.

A. The following groups are at risk for treatment resistance or noncompliance for the treatment of Tuberculosis (TB):

1) Members with demonstrated resistance to Isoniazid and Rifampin;

2) Members whose treatment has failed or who have relapsed after completing a prior regimen;

3) Substance users;

4) Members with mental health conditions or SUD;

5) Elderly, Children and adolescent Members;

6) Members with unmet housing needs;

7) Members with language and/or cultural barriers; and

8) Members who have demonstrated noncompliance by failing to keep office appointments.

B. Contractor must refer Members with active TB and Members who have treatment resistance or non-compliance issue risks to the TB control officer of the LHD for Direct Observed Therapy (DOT). If a Provider finds that a Member is at risk for treatment resistance or noncompliance with treatment, Contractor must refer the Member to the LHD for DOT.

C. Contractor must have an MOU in place as required in Exhibit A, Attachment III, Section 5.6 (*MOUs with Local Government Agencies, County Programs, and Third Parties*) to ensure joint case management and Care Coordination with the LHD TB Control Officer. Contractor must

provide all Medically Necessary Covered Services to Members with TB on DOT.

4.3.19 Women, Infants, and Children Supplemental Nutrition Program

A. Women, Infants, and Children (WIC) services are not covered under this Contract. However, Contractor must maintain procedures to identify and refer eligible Members for WIC services. Contractor must also have an MOU in place as required in Exhibit A, Attachment III, Section 5.6 (*MOUs with Local Government Agencies, County Programs, and Third Parties*) to ensure referrals. As part of the referral process, Contractor must provide the WIC program with the Member's current hemoglobin or hematocrit laboratory value. Contractor must also document the laboratory values and the referral in the Member's Medical Record.

B. Contractor must refer, and document the referral of, Members who are pregnant, breastfeeding, or postpartum, or a legal guardian for a Member under the age of five, to the WIC program either as part of the initial evaluation of newly pregnant women pursuant to 42 CFR section 431.635(c) and PL 98-010.

4.3.20 Home and Community-Based Services Programs

A. DHCS administers, either directly or through another State entity, a number of Medi-Cal Home and Community-Based Services (HCBS) programs authorized under the Medi-Cal program. HCBS programs provide long-term community-based services and supports to eligible Members in the community setting of their choice instead of in an institution.

B. Contractor must continue to provide all Covered Services to a Member when that Member is enrolled in, or applying to enroll in, receiving, or applying to receive an HCBS program other than this Contract. Contractor must continuously collaborate and exchange Member health care and medical information with all third-party entities providing the Member with Medi-Cal HCBS or administering a Medi-Cal-funded HCBS program pursuant to the third-party entity's contractual or legal authority to administer Medi-Cal-funded HCBS programs and/or provide HCBS to the Member. Such third-party entities include, but are not limited to:

1) DHCS;

2) State departments that operate or administer Medi-Cal programs offering HCBS pursuant to legal authority and/or Inter-Agency Agreements with DHCS, including but not limited to, the California Department of Social Services; the California Department of

Developmental Services, the California Department of Public Health (CDPH), and the California Department of Aging;

3) Home and Community Based Alternatives Waiver agencies;

4) Assisted Living Waiver Care Coordination agencies;

5) RCs;

6) Multipurpose Senior Services Program sites;

7) Medi-Cal Waiver Program agencies; and

8) California Community Transitions lead organizations.

C. Contractor must maintain procedures to identify Members who may benefit from Medi-Cal HCBS programs and refer Members to the third-party entity administrating the HCBS program. The HCBS programs include, but are not limited to HCBS programs authorized under the Social Security Act (SSA) at 42 USC section 1396n(c), the California Medicaid State Plan option authorized under 42 USC section 1396n(k), California Medicaid State Plan HCBS benefits authorized under 42 USC section 1396n(k), and other State and federally-funded Medi-Cal HCBS programs. If the Member is then authorized to receive Medi-Cal-funded HCBS program services, the Member must remain enrolled with Contractor and Contractor must continue to provide all services and benefits covered under this Contract to the Member.

D. Contractor's collaboration with third-party entities providing the Member with HCBS program services or administering a HCBS program pursuant to the third-party entity's contractual or legal authority to administer HCBS programs and/or provide HCBS program services to the Member, must include, but is not limited to:

1) Maintaining staff assigned to coordinate with such third-party entities that is sufficient to assist Members in understanding and accessing HCBS program services, and to act as a central point of contact for questions, access, and Care Coordination concerns.

2) Working in collaboration with such third-party entities' care managers and Providers to coordinate Covered Services, all HCBS program services, and any other relevant medical or supportive services. Such coordination must include, but is not limited to, the timely exchange of information regarding the Member and their health care needs, services, and efforts to obtain and arrange for

the provision of both Medi-Cal and non-Medi-Cal programs pursuant to DHCS guidance to Contractor and HCBS Providers.

3) As contracted delegates of the State, Contractor and such third-party entities administering HCBS programs and/or providing HCBS program services are authorized to share Member information with one another, including PHI/Personal Identifiable Information (PII) in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and Exhibit G of this Contract, because both are under a contract with DHCS, are legally authorized to receive such information, and/or are responsible for administration of the Medi-Cal program, complying with the provisions within their respective Business Associate Agreements with the State, and sharing this information with each other as part of their contractual responsibilities pursuant to and in compliance with 45 CFR sections 164.502(a)(1)(ii), 164.502(a)(3), and 164.506(c).

4.3.21 In-Home Supportive Services

Contractor must maintain policies and procedures for identifying and referring eligible Members to the county IHSS program. Contractor's procedures must address the following requirements, at a minimum:

A. Processes for coordinating with the county IHSS agency that ensures Members do not receive duplicative services through ECM, Community Supports, and other services;

B. Track all Members receiving IHSS and continue coordinating services with the county IHSS agency for Members until IHSS notifies Contractor that IHSS is no longer needed for the Member;

C. Designate a person to serve, as the day-to-day IHSS liaison with county IHSS agency.

1) Contractor, in collaboration with county IHSS agency, must ensure Contractor's IHSS liaison is sufficiently trained on IHSS assessment and referral processes and providers, and how Contractor and Primary Care Providers can support IHSS eligibility applications and coordinate care across IHSS, medical services, and long-term services and supports. This includes training on IHSS referrals for Members in inpatient and Skilled Nursing Facility settings as a part of Transitional Care Service requirements, to support safe and stable transitions to home and community-based settings.

2) The IHSS liaison functions may be assigned to the LTSS liaison as long as they meet the training requirements and have the expertise to work with the county IHSS liaison.

D. Outreach and coordinate with the county IHSS agency for any Members identified by DHCS as receiving IHSS;

E. Upon identifying Members receiving, referred to, or approved for IHSS, conduct a reassessment of Members' Risk Tier, per the population RSS and Risk Tiering requirements in this Section; and

F. Continue to provide Basic PHM and Care Coordination of all Medically Necessary services while Members receive IHSS.

4.3.22 Indian Health Care Providers

Contractor must have an identified tribal liaison dedicated to working with each Indian Health Care Provider (IHCP) in its Service Area and responsible for coordinating referrals and payment for services provided to Indian Members who are qualified to receive services from an IHCP, in accordance with the requirements in Exhibit A, Attachment III, Subsection 3.3.7 (*Federally Qualified Health Center, Rural Health Center, and Indian Health Care Provider*).

4.3.23 Justice Involved Reentry Coordination

Contractor must maintain policies and procedures for coordinating with Correctional Facilities and pre-release care managers in order to support Members who are leaving a Correctional Facility and reentering the community. Such policies and procedures must include all requirements as detailed in the Policy and Operational Guide for Planning and Implementing CalAIM Justice-Involved Initiative, including:

A. A designated Justice Involved liaison, as required in Exhibit A, Attachment III, Subsection 4.3.24 (*Managed Care Liaisons*);

B. Assigning ECM Providers to serve as pre-release care managers and/or as post-release ECM Providers for Justice Involved Individuals;

C. Coordinating the Member's transition from the pre-release to the post-release period, including any needed data sharing; and

D. Ensuring the provision of any Medically Necessary Covered Services including ECM, physical and behavioral health services, Community Supports, NEMT, and Non-Medical Transportation (NMT).

4.3.24 Managed Care Liaisons

Contractor must designate an individual or set of individuals to serve as the day-to-day liaisons for specific services and programs as set forth in the list below to ensure services are closely coordinated with Member's other services and to ensure effective oversight and delivery of services.

Liaisons must receive training on the full spectrum of rules and regulations pertaining to the service they are coordinating, including referral requirements and processes, care management, and authorization processes.

Contractor must notify the other party, for which they are serving as a liaison, of any changes to the liaison as soon as reasonably practical but no later than the date of change and must notify DHCS within five (5) days of the change.

Pursuant to the obligations set forth in this section, Contractor must designate the following liaisons:

A. Tribal liaison as required in Exhibit A, Attachment III, Subsection 4.3.22 (*Indian Health Care Providers*)

B. Long-Term Services and Supports (LTSS) Liaison

   LTSS Liaisons must receive training on the rules and regulations pertaining to Medi-Cal covered LTC, including payment and coverage policies; prompt claims payment requirements; Provider resolutions, policies and procedures; and care management, coordination and transition policies.

C. Transportation Liaison

   Contractor must have a direct line for Providers and Members to receive real-time assistance directly from Contractor with unresolved transportation issues that can result in missed appointments. The liaison role may not be delegated to a transportation broker. Contractor must also have a process to triage urgent transportation calls when the Member or Provider communicates that they have attempted to work with the broker but the issue remains unresolved and is time sensitive.

D. California Children's Services Liaison

   Contractor must have a CCS liaison(s) that serves as the primary point(s) of contact for the coordination of services between Contractor and County CCS Program to ensure the appropriate communication and Care Coordination are ongoing between the Contractor and County CCS Program, facilitate quarterly meetings, and provide updates to the County CCS Program as appropriate. CCS liaison(s) must receive training on the

full spectrum of rules and regulations pertaining to the County CCS Program, including referral requirements and processes, annual medical review processes with counties, care management and authorization processes for CCS Children.

E. County Child Welfare Liaison

1) Contractor must designate at least one individual to serve as the county child welfare liaison who will serve as a leader within Contractor to be the point of contact for child welfare departments and be the advocate on behalf of Members involved in county child welfare. Additional county child liaisons must be designated as needed to ensure the needs of Members involved with county child welfare are met.

2) Contractor's county child welfare liaison(s) will follow DHCS-issued standards and expectations as set forth in APLs or other similar instructions. Contractor's county child welfare liaison must:

a) Have expertise in Child welfare services, County Behavioral Health Services.

b) Ensure appropriate ECM staff, including the ECM Lead Care Manager whenever possible, attend meetings of the Child and family teams, in accordance W&I section 16501(a)(4), and ensure Covered services are closely coordinated with other services, including social services and Specialty Mental Health Care Services.

c) Act as a resource to ECM Providers providing services to Child welfare-involved Children and youth, provide technical assistance to Contractor and ECM Provider staff as needed, and serve as a point of escalation for care managers if they face operational obstacles when working with County and community partners.

d) Be sufficiently trained on County Care Coordination and assessment processes.

e) Provide resources and support to Member's care manager about Medi-Cal managed care plan Enrollment and disenrollment when they are made aware that the Member will move to a different county.

F. Justice Involved Liaison

1) Contractor must have an assigned Justice Involved liaison for justice involved reentry coordination, which may be one individual or multiple identified individuals, and make available information related to the Justice Involved liaison's title, name, contact phone number and email address.

2) The Justice Involved liaison must be available to support Correctional Facilities, pre-release care management Providers, and/or ECM Providers in the reentry planning process as required in Exhibit A, Attachment III, Subsection 4.3.23 (*Justice Involved Reentry Coordination)* and further specified in the Policy and Operational Guide for Planning and Implementing CalAIM Justice Involved Initiative.

G. RC Liaison as required in Exhibit A, Attachment III, Subsection 4.3.15 (*Services for Persons with Developmental Disabilities*)

H. Dental Liaison as required in Exhibit A, Attachment III, Subsection 4.3.17 (*Dental*)

I. IHSS Liaison as required in Exhibit A, Attachment III, Subsection 4.3.21 (*In-Home Support Services*)

Exhibit A, ATTACHMENT III

4.4 Enhanced Care Management

4.4.1 Contractor's Responsibilities for Administration of Enhanced Care Management
4.4.2 Populations of Focus for Enhanced Care Management
4.4.3 Enhanced Care Management Providers
4.4.4 Enhanced Care Management Provider Capacity
4.4.5 Enhanced Care Management Model of Care
4.4.6 Member Identification for Enhanced Care Management
4.4.7 Authorizing Members for Enhanced Care Management
4.4.8 Assignment to an Enhanced Care Management Provider
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4.4.11 Core Service Components of Enhanced Care Management
4.4.12 Data System Requirements and Data Sharing to Support Enhanced Care Management
4.4.13 Oversight of Enhanced Care Management Providers
4.4.14 Payment of Enhanced Care Management Providers
4.4.15 Enhanced Care Management Reporting Requirements
4.4.16 Enhanced Care Management Quality and Performance Incentive Program

4.4 Enhanced Care Management

4.4.1 Contractor's Responsibilities for Administration of Enhanced Care Management

A. Contractor must follow all provisions in the Enhanced Care Management (ECM) Policy Guide and DHCS Closed-Loop Referral (CLR) Implementation Guidance, in addition to provisions outlined in this Contract.

B. Contractor must take a whole-person approach to offering ECM, ensuring that ECM addresses the clinical and non-clinical needs of high-need and high-cost Members in distinct Populations of Focus (POF), Exhibit A, Attachment III, Subsection 4.4.2 (*Populations of Focus for Enhanced Care Management*), through systematic coordination of services and comprehensive care management.

C. Contractor must ensure ECM is community-based, interdisciplinary, high-touch, and person-centered.

D. Contractor must ensure ECM is available throughout its Service Area.

E. Contractor must ensure ECM is offered primarily through in-person interaction where Members and their family members, legal guardians, Authorized Representatives (ARs), caregivers, and authorized support persons live, seek care, or prefer to access services in their local community. Contractor must ensure its ECM Providers focus on building relationships with Members, and in-person visits may be supplemented with secure teleconferencing and Telehealth, when appropriate and with the Member's consent.

F. In situations where Contractor is performing ECM functions using Contractor's own staff, Contractor must follow the same requirements as an ECM Provider that is a Network Provider or Subcontractor**,** specifically that all such services are community-based, interdisciplinary, high-touch and person-centered. All such situations require DHCS approval through the exemption process and plans must be also making demonstrable progress to moving these ECM functions to community-based providers.

G. Contractor must follow the appropriate processes to ensure Members who may benefit from ECM receive ECM as defined in this Contract.

H. Contractor must ensure ECM provided to each Member encompasses the ECM core service components described in Exhibit A, Attachment III, Subsection 4.4.11 (*Core Service Components of Enhanced Care Management*).

I. Contractor must ensure a Member receiving ECM is not receiving duplicative case management services from other sources, including but not limited to county-specific Targeted Case Management (TCM) services administered by Local Governmental Agencies (LGAs).

J. For Members who are dually eligible for Medicare and Medi-Cal and enrolled in a Medicare Advantage Plan, Contractor must coordinate with the Medicare Advantage Plan for the provision of ECM for those Members.

K. Contractor must develop Member-facing written material about ECM for use across its network of ECM Providers. The written material must be submitted for DHCS review and approval prior to use. This material must include the following, at a minimum:

1) Explain ECM and how a Member may to request it;

2) Maintain a list of ECM Providers as part of its Provider Directory, adherent to requirements established in the ECM Policy Guide;

3) Explain that ECM participation is voluntary and can be discontinued at any time;

4) Explain that the Member must authorize ECM-related data sharing;

5) Describe the process by which the Member may choose a different ECM Lead Care Manager or ECM Provider; and

6) Meet standards for culturally and linguistically appropriate communication Exhibit A, Attachment III, Subsection 5.2.11 (*Cultural and Linguistic Programs and Committees*) and in Exhibit A, Attachment III, Subsection 5.1.3 (*Member Information*).

4.4.2 Populations of Focus for Enhanced Care Management

A. Subject to the phase-in and Member transition requirements described in Exhibit A, Attachment III, Subsection 4.4.6 (*Member Identification for Enhanced Care Management*).

B. Contractor must provide ECM to Members that meet the eligibility criteria for at least one of the following POF, as described in the ECM Policy Guide:

1) Members experiencing homelessness:

a) Members without dependent Children/youth living with them experiencing homelessness; and

b) Homeless families or unaccompanied Children/youth experiencing homelessness.

2) Members at risk for avoidable hospital or emergency department utilization;

3) Members with serious mental health and/or Substance Use Disorder (SUD) needs;

4) Members transitioning from incarceration;

5) Adult Members living in the community and at risk for Long-Term Care (LTC) institutionalization;

6) A Member residing in an adult nursing facility transitioning to the community;

7) Children enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM) with additional needs beyond the CCS condition;

8) Children involved in Child welfare; and

9) Birth equity POF.

C. Contractor may offer ECM to Members who do not meet POF criteria in full but may benefit from ECM.

D. Contractor must follow all applicable DHCS policies and guidance, including All Plan Letters (APLs) and the ECM Policy Guide, that further define the approach to ECM for each POF, including the eligibility criteria for each POF and the phase-in timeline for POF, and the JI Policy and Operations guide, that further define the approach to ECM for the Justice Involved POF.

E. To avoid duplication between existing care management and coordination approaches, Members are excluded from ECM while enrolled in the following programs:

1) 1915(c) waiver programs including:

a) Multipurpose Senior Services Program (MSSP);

b) Assisted Living Waiver (ALW);

c) Home and Community-Based Alternatives (HCBA) Waiver;

d) Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) Waiver;

e) HCBS programs for Individuals with Developmental Disabilities (DD); and

f) Self-Determination Program for Individuals with intellectual and DD.

2) Fully integrated programs for Members dually eligible for Medicare and Medicaid including:

a) Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs);

b) Program for All-Inclusive Care for the Elderly (PACE);

c) Exclusively Aligned Enrollment (EAE) Dual Special Needs Plans (D-SNPs); and

d) Non EAE D-SNPs.

3) California Community Transitions (CCT) Money Follows the Person (MFTP)

4) Complex Care Management (CCM)

4.4.3 Enhanced Care Management Providers

A. Contractor must ensure ECM is provided primarily through in-person interaction in settings that are most appropriate for the Member, such as where the Member lives, seeks care, or prefers to access services in their local community.

B. ECM Providers may include, but are not limited to, the following entities:

1) Counties;

2) County Behavioral Health Providers;

3) Primary Care Provider (PCP) or Specialist or Physician groups;

4) Federally Qualified Health Centers (FQHCs);

5) Community health centers;

6) Community-based organizations;

7) Hospitals or hospital-based Physician groups or clinics (including public hospitals or district or municipal public hospitals);

8) Rural Health Clinics (RHCs) or Indian Health Care Providers (IHCP);

9) Local Health Departments (LHDs);

10) Behavioral Health entities;

11) Community mental health centers;

12) SUD treatment Providers;

13) Community Health Workers (CHW);

14) Organizations serving individuals experiencing homelessness;

15) Organizations serving justice-involved individuals;

16) CCS Providers; and

17) Other qualified Providers or entities that are not listed above, as approved by DHCS.

C. For the POF for eligible individuals with Serious Mental Illness (SMI) or SUD and the POF for eligible individuals with Contractor must prioritize county Behavioral Health staff or Behavioral Health Providers to serve in the ECM Provider role, provided they agree and are able to coordinate all services needed by those POF, not just their Behavioral Health Services.

D. Contractor must attempt to contract with each IHCP as set forth in 22 CCR sections 55110 through 55180 to provide ECM, when applicable, as described in Exhibit A, Attachment III, Subsection 3.3.7 (*Federally Qualified Health Center, Rural Health Center, and Indian Health Care Provider*).

E. Contractor must ensure ECM Providers meet the requirements set forth in APLs including but not limited to the requirements regarding the use of a care management documentation system.

F. Care management documentation systems may include certified electronic health record technology, or other documentation tools that can:

1) Document Member goals and goal attainment status;

2) Develop and assign care team tasks;

3) Define and support Member Care Coordination and Care Management needs; and

4) Gather information from other sources to identify Member needs and support care team coordination and communication; and support notifications regarding Member health status and transitions in care (e.g., discharges from a hospital, LTC facility, housing status).

G. Contractor must also comply with requirements on data exchange pursuant to Exhibit A, Attachment III, Subsection 4.4.12 (*Data System Requirements and Data Sharing to Support Enhanced Care Management*).

H. Contractor must ensure all ECM Providers for whom a State-level Enrollment pathway exists enroll in Medi-Cal, pursuant to relevant APLs, including APL 22-013 (Provider Credentialing/Recredentialing and Screening/Enrollment). If APL 22-013 does not apply to an ECM Provider, Contractor must have a process for verifying qualifications and experience of ECM Providers, which must extend to individuals employed by or delivering services on behalf of the ECM Provider. Contractor must ensure that all ECM Providers meet the capabilities and standards required to be an ECM Provider.

I. Contractor must not require eligible ECM Providers to be National Committee for Quality Assurance (NCQA) certified or accredited as a condition of entering into a Subcontractor Agreement or Network Provider Agreement, as appropriate.

J. Contractor must ensure ECM Providers serving the Justice Involved POF meet not only the standard ECM Provider requirements, but requirements outlined in the JI Policy and Operational Guide for Planning and Implementing the Justice Involved Initiative, including, but not limited to:

1) Meeting the following criteria pertaining to participation in pre-release care management services and warm handoffs:

a) If the Correctional Facilities in the ECM Provider's county of operation leverage an in-reach care management model, Contractor must ensure that JI ECM Providers offer pre-release care management services as in-reach care management Providers and continue to serve the Member post-release as the Member's ECM Provider.

b) If the Correctional Facilities in the ECM Provider's county of operation leverage an embedded care management model, Contractor must ensure that the ECM Provider participates in a warm handoff with the pre-release embedded care manager and the Member.

2) ECM Providers must bill Fee-for-Service (FFS) for all pre-release care management services and warm handoffs by either enrolling through the Provider Application and Validation for Enrollment (PAVE) system or contracting with the Correctional Facility to provide services billed under the Correctional Facility National Provider Identifier (NPI).

4.4.4 Enhanced Care Management Provider Capacity

A. Contractor must develop and manage a network of ECM Providers.

B. Contractor must ensure sufficient ECM Provider capacity to meet the unique needs of all ECM POF, including by contracting with providers with specific skills and experience serving specific POF.

C. Contractor must meet DHCS' requirements regarding ECM Provider capacity separately from general Network adequacy; ECM Provider capacity does not alter the general Network adequacy provisions in Exhibit A, Attachment III, Section 5.2 (*Network and Access to Care*).

D. Contractor must report on its ECM Provider capacity to DHCS initially in its ECM Model of Care (MOC) Template as referenced in Exhibit A, Attachment III, Subsection 4.4.*5 (Enhanced Care Management Model of Care)* and on an ongoing basis pursuant to DHCS reporting requirements in a form and manner specified by DHCS.

E. Contractor must report to DHCS any Significant Changes in its ECM Provider capacity as soon as possible but no later than 60 days from the occurrence of the change, in accordance with DHCS reporting requirements in a form and manner specified by DHCS.

F. If Contractor is unable to provide sufficient capacity to meet the needs of all ECM POF through Subcontractor or Network Provider Agreements, as

appropriate, with community-based ECM Providers, Contractor may submit a written request to DHCS for an exception that authorizes Contractor to use its own personnel for ECM. Any such request must be submitted in accordance with DHCS guidelines and must meet at least one of the following criteria:

1) There are insufficient ECM Providers, or a lack of ECM Providers with qualifications and experience, to provide ECM for one or more of the POF in one or more counties;

2) There is a justified Quality of Care concern with one or more of the otherwise qualified ECM Providers;

3) Contractor and the ECM Providers are unable to agree on rates;

4) ECM Providers are unwilling to contract;

5) ECM Providers are unresponsive to multiple attempts to contract;

6) ECM Providers who have a State-level pathway to Medi-Cal Enrollment but are unable to comply with the Medi-Cal Enrollment process or Contractor's verification requirements for ECM Providers; or

7) ECM Providers without a State-level pathway to Medi-Cal Enrollment that are unable to comply with Contractor's verification requirements for ECM Providers.

G. During an exception period approved by DHCS, Contractor must take steps to continually develop and increase its ECM Network capacity. After the expiration of an exception period, Contractor must submit a new exception request to DHCS for DHCS review and approval on a case-by-case basis.

H. Contractor's failure to provide network capacity that meets the needs of all ECM POF in a community-based manner may result in imposition of Corrective Action proceedings, and may result in sanctions pursuant to Exhibit E, Section 1.19 (*Sanctions*).

I. Contractor must ensure Network overlap of the Justice Involved pre-release care management Provider network and the Justice Involved ECM Provider network across Contractor's Service Area. Contractor must submit to DHCS, for prior approval, any requests for exception from Network overlap requirements across Medi-Cal managed care plans in the same county for one of the permissible reasons as described in the JI

Policy and Operational Guide for Planning and Implementing the Justice Involved Initiative.

4.4.5 Enhanced Care Management Model of Care

A. Contractor must develop an ECM MOC template in accordance with the DHCS-approved MOC Template. The MOC must specify Contractor's framework for providing ECM, including a listing of its ECM Providers and policies and procedures for partnering with ECM Providers for the provision of ECM.

B. In developing and executing Subcontractor Agreements or Network Provider Agreements, as appropriate, with ECM Providers, Contractor must incorporate all requirements and policies and procedures described in its MOC, in addition to APLs.

C. Contractor may collaborate with other Medi-Cal managed care health plans within the same county on the development of its MOC as applicable for Contractor's plan model.

D. Contractor must submit its ECM MOC for DHCS review and approval. Contractor must also submit to DHCS any Significant Changes to its MOC for DHCS review and approval at least 60 calendar days in advance of any occurrence of changes or updates, in accordance with DHCS policies and guidance, including APLs. Significant Changes may include, but are not limited to, changes to Contractor's approach to administering or delivering ECM services, approved policies and procedures, and Subcontractor Agreement and Downstream Subcontractor Agreement boilerplates.

4.4.6 Member Identification for Enhanced Care Management

A. Contractor must proactively identify Members who may benefit from ECM and who meet the eligibility criteria for the ECM POF, as described in Exhibit A, Attachment III, Subsection 4.4.2 (*Populations of Focus for Enhanced Care Management*).

B. To identify such Members, Contractor must consider the following:

1) Members' health care utilization;

2) Needs across physical, behavioral, developmental, and oral health;

3) Health risks and needs due to Social Drivers of Health; and,

4) Long-Term Services and Supports needs.

C. Contractor must identify Members for ECM through the following pathways:

1) Analysis of Contractor's own enrollment, claims, and other relevant data and available information. Contractor must use data analytics to identify Members who may benefit from ECM and who meet the criteria for the ECM POF. Contractor must consider data sources, including but not limited to:

a) Enrollment data;

b) Encounter Data;

c) Utilization/claims data;

d) Pharmacy data;

e) Laboratory data;

f) Screening or assessment data;

g) Clinical information on physical and Behavioral Health;

h) SMI/SED/SUD data, if available;

i) Risk stratification information for Children in County Organized Health System (COHS) counties with WCM programs;

j) Information about Social Drivers of Health, including standardized assessment tools including Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) and International Classification of Diseases, Tenth Revision (ICD-10) codes;

k) Results from any available Adverse Childhood Experience (ACE) screening; and

l) Other cross-sector data and information, including housing, social services, foster care, criminal justice history, and other information relevant to the ECM POF (e.g., Homeless Management Information System (HMIS), available data from the education system).

2) Receipt of requests from ECM Providers and other Providers or community-based entities.

   a) Contractor must accept requests for ECM on behalf of Members from:

      i. ECM Providers;

      ii. Social service or other Providers; and

      iii. Community-based entities, including those contracted to provide Community Supports, as described in Exhibit A, Attachment III, Subsection 4.5.4(*Community Supports Providers)*.

   b) Contractor must update its ECM referral forms and tools to reflect requirements in the *ECM Referral Standards and Form Templates.*

   c) Contractor must not require nor request community partners or ECM Providers to submit supplemental eligibility checklists, outreach authorization forms, ICD-10 codes, additional proof of homelessness, Treatment Authorization Request (TAR) forms, or other supplemental information beyond the information provided in the ECM Referral Standards to confirm eligibility and authorize ECM.

   d) Contractor must designate an email and dedicated phone number that is widely available by which referrals can be made.

   e) Contractor must directly engage with and provide training to Network Providers, Subcontractors, Downstream Subcontractors, and county agencies to inform these entities of ECM, the ECM POF, and how to request ECM for Members, with the goal of having the majority of ECM eligible Member referrals coming from Providers and community sources, rather than Contractor identification.

   f) Contractor must encourage ECM Providers to identify Members who meet the criteria for the ECM POF, and must use *ECM Referral Standards and Form Templates* to receive referral requests from ECM Providers.

3) Requests from Members

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

b) Contractor must provide information to Members regarding the Member initiated ECM request and approval process.

4) For pre-release services under the Justice Involved Reentry Initiative, Contractor must have processes that:

a) Identify any Member who received pre-release services for presumptive eligibility and enrollment in ECM, including using the JI aid code for enrolled Members.

b) Receive notifications of pre-release services from Correctional Facilities or their contracted pre-release care managers through their JI liaison.

c) Receive notifications from the ECM Provider who is acting as the pre-release care manager or who has received a warm handoff.

4.4.7 Authorizing Members for Enhanced Care Management

A. Contractor must authorize ECM for each eligible Member identified through any of the pathways described in Exhibit A, Attachment III, Subsection 4.4.6 (*Member Identification for Enhanced Care Management*). If a Member meets ECM POF eligibility requirements, Contractor must authorize ECM without additional requirements.

B. Contractor must develop policies and procedures that explain how it will authorize ECM for eligible Members in an equitable and non-discriminatory manner.

C. For requests from Providers and other external entities, Members, Member's parent, family member, legal guardian, AR, caregiver, or authorized support person:

1) Contractor must ensure that authorization or a decision not to authorize ECM occurs as soon as possible and in accordance with Exhibit A, Attachment III, Subsection 2.3.2 (*Timeframes for Medical Authorization*) and APL 21-011;

2) If Contractor does not authorize ECM, Contractor must ensure the Member and the requesting individual or entity who requested ECM

on a Member's behalf, as applicable, are informed of the Member's right to Appeal and the Appeals process by way of the Notice of Action (NOA) process as described in Exhibit A, Attachment III, Subsection 5.1.5 (*Notices of Action for Denial, Deferral, or Modification of Prior Authorization Requests*), and Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*) and APL 21-011; and

3) Contractor must follow its standard Grievances and Appeals process outlined in Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*) and APL 21-011.

D. Contractor must develop policies and procedures to implement ECM Streamlined Authorization in alignment with the *ECM Policy Guide* with in-network ECM Providers serving the below specified POF:

1) Adults and Children Experiencing Homelessness POF: Street Medicine Providers; Community Supports Providers of Transitional Rent and the Housing Trio Services: Housing Transition Navigation Services, Housing Deposits, and Housing Tenancy and Sustaining Services; County-contracted and County-operated Specialty Behavioral Health Providers

2) Adults and Children at risk for avoidable hospital or ED Utilization POF: Primary Care Practices.

3) Adults and Children with Serious Mental Health and/or SUD Needs POF: County-contracted and County-operated Specialty Behavioral Health Providers.

4) Adults Living in the Community and At Risk for LTC Institutionalization POF: Community Supports Providers of the Assisted Living Facility Transitions and community or home transition services; California Community Transitions (CCT) Lead Organizations.

5) Adult SNF Residents Transitioning to the Community POF: Community Supports Providers of the Assisted Living Facility Transitions and community or home transition services; California Community Transitions (CCT) Lead Organizations.

6) Children and Youth Enrolled in CCS/CCS WCM POF: CCS Paneled Providers and Local Health Department County CCS Programs.

7) Children and Youth Involved in Child Welfare POF: County-Contracted and County-Operated Specialty Behavioral Health Providers; High Fidelity Wraparound Providers; Health Care Program for Children in Foster Care Providers; California Department of Social Services (DSS) Offices; Foster Family Agencies; Transitional Housing Programs for Current and Former Foster Youth.

8) Birth Equity POF: OBGYN Practices; Midwifery Practices; Entities that deliver the following services: Black Infant Health Program, Perinatal Equity Initiative, Indian Health Program, American Indian Maternal Support Services.

E. Contractor must implement ECM Streamlined Authorization arrangements that enable ECM Providers to initiate and be reimbursed for ECM services for a 30 calendar day timeframe. Contractors must allow network ECM Providers under ECM Streamlined Authorization to start billing for ECM services from the date the Member first receives ECM services. In a case where the Contractor subsequently denies the ECM authorization, the Contractor must reimburse the ECM Provider throughout the ECM Streamlined Authorization timeframe up until the end of the day that the Contractor makes an authorization determination and communicates the denial to the ECM Provider. Contractor has two exemptions for requirement for payment in the ECM Streamlined Authorization timeframe:

1) Contractors are not responsible for reimbursing for ECM services for individuals who are not Members of their Managed Care Plan during the time of ECM service delivery.

2) Contractors are not responsible for reimbursing for ECM services in cases when the Contractor determines that a Member has an existing, open ECM authorization with another ECM Provider.

F. Contractors must make Members' ECM authorization statuses accessible to ECM Providers via their Plan Portal or similar online system by January 1, 2025, to support ECM Providers in accessing a Member's existing ECM authorization information to support implementation of ECM Streamlined Authorization requirements.

G. Contractor must authorize ECM services for all Members who were found eligible for pre-release services under the CalAIM Justice Involved Reentry Initiative. ECM services are authorized for 12 months per the Policy and Operational Guide for Planning and Implementing CalAIM Justice-Involved Reentry Initiative.

H. To inform Members that ECM has been authorized, Contractor must follow its standard notice process outlined in Exhibit A, Attachment III, Subsection 5.1.5 (*Notices of Action for Denial, Deferral, or Modification of Prior Authorization Requests*) and APL 21-011.

4.4.8 Assignment to an Enhanced Care Management Provider

A. Contractor must assign every Member authorized for ECM to an ECM Provider. Contractor may assign Members to Contractor itself only with a DHCS-approved exception to the ECM Provider contracting requirement as described in Exhibit A, Attachment III, Subsection 4.4.4 (*Enhanced Care Management Provider Capacity*).

B. Contractor must develop a process to disseminate information of assigned Members to ECM Providers on a regular basis.

C. Contractor must ensure communication of Member Assignment to the designated ECM Provider occurs within ten Working Days of authorization or on an agreed upon schedule.

D. Pursuant to the Policy and Operational Guide for Planning and Implementing CalAIM Justice-Involved Reentry Initiative, for Members eligible for pre-release services under the CalAIM Justice Involved Reentry 1115 Initiative, Contractor must, to the extent possible, assign an ECM Provider that was the pre-release care manager or the care manager who received a warm handoff from the Correctional Facility while the individual was incarcerated.

E. If a Member prefers a specific ECM Provider, Contractor must assign the Member to that Provider, to the extent practicable.

F. If a Member's assigned PCP is a contracted ECM Provider, Contractor must assign the Member to the PCP as the ECM Provider, unless the Member indicates otherwise or Contractor identifies a more appropriate ECM Provider given the Member's individual needs and health conditions.

G. If a Member receives services from a MHP for SED, SUD, or SMI and the Member's Behavioral Health Provider is a contracted ECM Provider, Contractor must assign that Member to that Behavioral Health Provider as the ECM Provider, unless the Member indicates otherwise or Contractor identifies a more appropriate ECM Provider given the Member's individual needs and health conditions.

H. If a Member is enrolled in CCS and the Member's CCS Case Manager is Affiliated with a contracted ECM Provider, Contractor must assign that Member to that CCS Case Manager as the ECM Provider, unless the

Member or parent, legal guardian, or AR has indicated otherwise or Contractor identifies a more appropriate ECM Provider given the Member's individual needs and health conditions.

I. Contractor must notify the Member's PCP, if different from the ECM Provider, of the assignment to the ECM Provider, within ten Working Days of the date of assignment.

J. Contractor must document the Member's ECM Lead Care Manager in its system of record.

K. Contractor must permit Members to change ECM Providers at any time. Contractor must implement any Member's request to change their ECM Provider within 30 calendar days to the extent practicable.

4.4.9 Initiating Delivery of Enhanced Care Management

A. Contractor must not require Member authorization for ECM-related data sharing (whether in writing or otherwise) as a condition of initiating delivery of ECM, unless such authorization is required by federal law.

B. Contractor must develop policies and procedures for its network of ECM Providers that meet the following requirements, including but not limited to:

1) Where required by law, ECM Providers must obtain Member's authorization to share information with Contractor and all others involved in the Member's care to maximize the benefits of ECM; and

2) ECM Providers must provide Contractor with Member-level records of any obtained authorizations for ECM-related data sharing as required by federal law and to facilitate ongoing data sharing with Contractor.

C. Contractor must ensure that upon the initiation of ECM, each Member receiving ECM has an ECM Lead Care Manager with responsibility for interacting directly with the Member and the Member's family, legal guardians, ARs, caregivers, and other authorized support persons, as appropriate.

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

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

4.4.10 Discontinuation of Enhanced Care Management

A. Contractor must ensure Members are able to decline or end ECM upon initial outreach and engagement, or at any other time.

B. Contractor must require the ECM Provider to notify Contractor to discontinue ECM for Members when any of the following circumstances are met:

1) The Member has met all care plan goals;

2) The Member is ready to transition to a lower level of care;

3) The Member no longer wishes to receive ECM or is unresponsive or unwilling to engage; or

4) The ECM Provider has not been able to connect with the Member after multiple attempts.

C. Contractor must develop processes to determine if the Member is no longer authorized to receive ECM and, if so, to notify the ECM Provider to initiate discontinuation of services in accordance with the NOA process described in Exhibit A, Attachment III, Subsection 5.1.5 (*Notices of Action for Denial, Deferral, or Modification of Prior Authorization Requests*); Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*); and APL 21-011.

D. Contractor must develop processes for transitioning Members from ECM to other levels of care management to provide coordination of ongoing Member needs.

E. Contractor must notify the ECM Provider when ECM has been discontinued by Contractor.

F. Contractor must notify the Member of the discontinuation of the ECM benefit and ensure the Member is informed of their right to Appeal and the Appeals process by way of the NOA process as described in Exhibit A, Attachment III, Subsection 5.1.5 (*Notices of Action for Denial, Deferral, or Modification of Prior Authorization Requests*), and Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*) and APL 21-011.

4.4.11 Core Service Components of Enhanced Care Management

Contractor must ensure all Members receive all of the following seven ECM core service components, as further defined in APLs:

A. Outreach and engagement;

B. Comprehensive assessment and Care Management Plan (CMP);

C. Enhanced coordination of care;

D. Health promotion;

E. Comprehensive transitional care;

F. Member and family supports; and

G. Coordination of and referral to community and social support services.

4.4.12 Data System Requirements and Data Sharing to Support Enhanced Care Management

A. Contractor must have an IT infrastructure and data analytic capabilities to support ECM, including the capabilities to:

1) Consume and use claims and Encounter Data, as well as other data types listed in Exhibit A, Attachment III, Subsection 4.4.6 (*Member Identification for Enhanced Care Management*);

2) Assign Members to ECM Providers;

3) Keep records of Members receiving ECM and authorizations necessary for sharing PHI and PI between Contractor and ECM and other Providers, among ECM Providers and family member(s) and/or support person(s), whether obtained by ECM Provider or by Contractor;

4) Securely share data with ECM Providers and other Providers in support of ECM;

5) Receive, process, and send Encounter Data from ECM Providers to DHCS;

6) Receive and process supplemental reports from ECM Providers;

7) Send ECM supplemental reports to DHCS; and

8) Open, track, and manage referrals to Community Supports Providers.

B. To support ECM, Contractor must follow DHCS guidance on data sharing and provide the following information to all ECM Providers:

1) Member Assignment files, defined as a list of Medi-Cal Members authorized for ECM and assigned to the ECM Provider;

2) Encounter Data and claims data;

3) Physical, behavioral, administrative, and Social Drivers of Health data (e.g., HMIS data) for all Members assigned to the ECM Provider; and

4) Reports of performance on quality measures and metrics, as requested.

C. Contractor must use defined federal and State standards, specifications, code sets, and terminologies when sharing physical, behavioral, social, and administrative data with ECM Providers and with DHCS in compliance with data exchange policies and procedures, as defined by the California Health and Human Services Data Exchange Framework, in accordance with H&S section 130290 and APL or other guidance.

4.4.13 Oversight of Enhanced Care Management Providers

A. Contractor must perform oversight of ECM Providers, holding them accountable to all ECM requirements contained in this Contract, DHCS policies and guidance, APLs, and Contractor's MOC.

1) Contractor must evaluate the prospective Subcontractor's and Downstream Subcontractor's ability to perform services as described in Exhibit A, Attachment III, Subsection 3.1.4 (*Contractor's Duty to Ensure Subcontractor, Downstream Subcontractor, and Network Provider Compliance*);

2) Contractor must ensure the Subcontractor's and Downstream Subcontractor's capacity is sufficient to serve all POF;

3) Contractor must report to DHCS the names of all Subcontractors, Network Providers, and Downstream Subcontractors by Subcontractor and Downstream Subcontractor type and service(s) provided, and identify the county or counties in which Members are served as described in Exhibit A, Attachment III, Subsection 3.1.3

(*Contractor's Duty to Disclose All Delegated Relationships and to Submit Delegation Reporting and Compliance Plan*); and

4) Contractor must make all Subcontractor Agreements or Network Provider Agreements, as appropriate, available to DHCS upon request. Such agreements must contain minimum required information specified by DHCS, including method and amount of compensation as described in Exhibit A, Attachment III, Subsection 3.1.5.B (*Subcontractor and Downstream Subcontractor Agreement Requirements*).

B. Contractor may hold ECM Providers responsible for the same reporting requirements as those Contractor has with DHCS to support data collection and reporting.

1) Contractor must not impose mandatory reporting requirements that differ from or are additional to those required for Encounter and supplemental reporting; and

2) Contractor may collaborate with other Medi-Cal Managed Care Health Plans within the same county on oversight of ECM Providers.

C. Contractor must not utilize tools developed or promulgated by NCQA to perform oversight of ECM Providers, unless by mutual consent with the ECM Provider.

D. Contractor must provide ECM training and technical assistance to ECM Providers, including in-person sessions, webinars, or calls, as necessary, in addition to Network Provider training requirements, as applicable, described in Exhibit A, Attachment III, Subsection 3.2.5 (*Network Provider Training).*

E. Contractor must ensure the Subcontractor Agreement and Downstream Subcontractor Agreement mirrors the requirements set forth in this Contract and in accordance with APLs, as applicable to Subcontractor.

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

4.4.14 Payment of Enhanced Care Management Providers

A. Contractor must pay ECM Providers for the provision of ECM in accordance with Subcontractor Agreements or Network Provider Agreements established between Contractor and each ECM Provider.

B. Contractor must ensure that ECM Providers are eligible to receive payment when ECM is initiated for any given Member, as described in Exhibit A, Attachment III, Subsection 4.4.9 (*Initiating Delivery of Enhanced Care Management*).

C. Contractor may tie ECM Provider payments to value, including payment strategies and arrangements that focus on achieving outcomes related to high-quality care and improved health status.

D. Contractor must utilize the claims timeline as described in Exhibit A, Attachment III, Subsection 3.3.5 (*Claims Processing*).

4.4.15 Enhanced Care Management Reporting Requirements

A. Contractor must submit the following data and reports to DHCS to support DHCS' oversight of ECM:

1) Encounter Data:

a) Contractor must submit all ECM Encounter Data to DHCS using national standard specifications and code sets to be defined by DHCS.

b) Contractor must submit to DHCS all Encounter Data for ECM services to its Members, regardless of the number of levels of delegation and/or sub-delegation between Contractor and the ECM Provider.

c) In the event the ECM Provider is unable to submit ECM Encounter Data to Contractor using the national standard specifications and code sets to be defined by DHCS, Contractor is responsible for converting the ECM Provider's Encounter Data information into the national standard specifications and code sets, for submission to DHCS.

2) ECM supplemental reports, on a schedule and in a format to be defined by DHCS.

B. Contractor must track and report to DHCS, on a schedule and in a format specified by DHCS, information about outreach efforts related to Potential Members to be enrolled in ECM.

C. In the event of underperformance by Contractor in relation to its administration of ECM, DHCS may impose sanctions as described in Exhibit E, Section 1.19 (*Sanctions*).

4.4.16 Enhanced Care Management Quality and Performance Incentive Program

A. Contractor must meet all quality management and Quality Improvement requirements in Exhibit A, Attachment III, Section 2.2 (*Quality Improvement and Health Equity Transformation Program (QIHETP)*) and any additional quality requirements set forth in associated guidance from DHCS for ECM.

B. Contractor may participate in a performance incentive program related to building Provider capacity for ECM, related health care quality and outcomes, and other performance milestones and measures, in accordance with APL 23-003 or other technical guidance.

Exhibit A, ATTACHMENT III

4.5 Community Supports

4.5.1 Contractor's Responsibility for Administration of Community Supports
4.5.2 Optional Community Supports
4.5.3 Transitional Rent
4.5.4 Community Supports Providers
4.5.5 Community Supports Provider Capacity
4.5.6 Community Supports Model of Care
4.5.7 Identifying Members for Community Supports
4.5.8 Authorizing Members for Community Supports and Communication of Authorization Status
4.5.9 Referring Members to Community Supports Providers for Community Supports
4.5.10 Data System Requirements and Data Sharing to Support Community Supports
4.5.11 Contractor's Oversight of Community Supports Providers
4.5.12 Delegation of Community Supports Administration to Network Providers, Subcontractors, or Downstream Subcontractors
4.5.13 Payment of Community Supports Providers
4.5.14 Community Supports Reporting Requirements
4.5.15 Community Supports Quality and Performance Incentive Program

4.5 Community Supports

For the purposes of this Section, "California Medicaid State Plan Covered Service or Setting" means any health service or care environment approved and funded under the California Medicaid State Plan, such as inpatient services, nursing facilities, or home health care.

For the purposes of this Section, the definitions of "homeless" and "at risk of homelessness" are as defined in 24 Code of Federal Regulations (CFR) section 91.5 with the following set of modifications (A, B, and C):

A. If exiting an institution, an individual is considered homeless if they were homeless immediately prior to entering that institutional stay or become homeless during that stay, regardless of the length of the institutionalization.

B. The timeframe for an individual or family who will imminently lose housing is extended to 30 days, which is a modification from the 14 days for an individual or family considered "homeless" and 21 days for an individual or family considered "at risk of homelessness" under 24 CFR section 91.5.

C. The requirement under the definition of "at risk of homelessness" for an individual or a family to have an annual income below 30 percent of the median family income for the area does not apply.

4.5.1 Contractor's Responsibility for Administration of Community Supports

A. Contractor may provide Community Supports as described in Exhibit A, Attachment III, Subsection 4.5.2 (*Optional Community Supports*). Contractor must provide Transitional Rent as described in Exhibit A, Attachment III, Subsection 4.5.3 (*Transitional Rent*).

B. In accordance with 42 CFR section 438.3(e)(2) and California Medicaid Section 1115 Demonstration Projects and the Member rights and protections defined within, all applicable All Plan Letters (APLs) Contractor may select and offer Community Supports from the list of optional Community Supports pre-approved by DHCS as medically appropriate and cost-effective substitutes for Covered Services or settings under the California Medicaid State Plan. See Exhibit A, Attachment III, Subsection 4.5.2 (*Optional Community Supports*) below for the list of optional Community Supports.

C. In accordance with California Medicaid Section 1115 Demonstration Projects, Contractor must provide Transitional Rent. See Exhibit A, Attachment III, Subsection 4.5.3 (*Transitional Rent*).

D. With respect to all Community Supports, including Transitional Rent:

1) Contractor must ensure medically appropriate California Medicaid State Plan services are available to the Member regardless of whether the Member has been offered Community Supports, is currently receiving Community Supports, or has received Community Supports in the past.

2) Contractor must not require a Member to utilize Community Supports. Members always retain their right to receive the California Medicaid State Plan services on the same terms as would apply if Community Supports was not an option in accordance with regulatory and California Medicaid Section 1115 Demonstration Projects' requirements.

3) Contractor must not use Community Supports to reduce, discourage, or jeopardize Members' access to California Medicaid State Plan services.

4) Contractor may submit a request to DHCS to offer Community Supports in addition to those Community Supports described in Exhibit A, Attachment III, Subsection 4.5.2 (*Optional Community Supports*) and Exhibit A, Attachment III, Subsection 4.5.3 (*Transitional Rent*).

5) Contractor must adhere to DHCS guidance on service definitions, eligible populations, code sets, potential Community Supports Providers, and parameters for each Community Support that Contractor chooses to provide or is required to provide, as set forth in APL or other guidance.

E. With respect to optional Community Supports:

1) Contractor is not permitted to extend Community Supports to Members beyond those for whom DHCS has determined the Community Supports will be cost-effective and medically appropriate through the established eligibility criteria described in Exhibit A, Attachment III, Subsection 4.5.2 (*Optional Community Supports)*.

2) Contractor may not adopt a more narrowly defined eligible population for Community Supports than outlined in Exhibit A, Attachment III, Subsection 4.5.2 (*Optional Community Supports*). That Subsection details (i) the name and definition of each Community Support; (ii) the Covered Services or settings under the California Medicaid State Plan that each Community Support may replace; (iii) the target populations for each Community Support;

(iv) Member rights and protections; and (v) the requirement to use State-designated codes in Encounter Data for each Community Support.

3) If Contractor elects to offer one or more Community Supports, it need not offer the Community Supports in each county it serves. Contractor must report to DHCS the counties in which it intends to offer the Community Supports. Contractor must provide Community Supports in a county selected by Contractor in accordance with the requirements set forth in Exhibit A, Attachment III, Subsection 4.5.5 (*Community Supports Provider Capacity*).

F. With respect to Transitional Rent:

1) Contractor is not permitted to extend Transitional Rent to Members beyond those who meet the established eligibility criteria described in Exhibit A, Attachment III, Subsection 4.5.3 *(Transitional Rent*).

2) Contractor must not adopt a more narrowly defined eligible population for Transitional Rent than outlined in Exhibit A, Attachment III, Subsection 4.5.3 (*Transitional Rent*).

3) Contractor must provide Transitional Rent in accordance with the requirements set forth in Exhibit A, Attachment III, Subsection 4.5.5 (*Community Supports Provider Capacity*).

G. Contractor must identify Members eligible for Community Supports and accept requests for Community Supports from Members and Members' Providers and organizations that serve them, including community-based organizations as described in Exhibit A, Attachment III, Subsection 4.5.7 (*Identifying Members for Community Supports*).

H. Contractor must authorize Community Supports for Members deemed eligible in accordance with Exhibit A, Attachment III, Subsection 4.5.8 (*Authorizing Members for Community Supports and Communication of Authorization Status*).

I. Contractor may provide voluntary services that are neither State-approved Community Supports nor Covered Services when medically appropriate for the Member, in accordance with 42 CFR section 438.3(e)(1). Such voluntary services are not subject to the terms of this Section and are subject to the limitations of 42 CFR section 438.3(e)(1). Contractor may offer voluntary services in addition to offering Community Supports, and may offer voluntary services even if Contractor does not offer Community Supports.

J. In the event of any discontinuation of Community Supports resulting in a change in the availability of services, Contractor must adhere to the requirements set forth in Exhibit A, Attachment III, Subsection 5.2.9 (*Network and Access Changes to Covered Services*).

K. When Members are dually eligible for Medicare and Medi-Cal, and enrolled in a Medicare Advantage Plan, including a Dual Special Needs Plan (D-SNP), Contractor must coordinate with the Medicare Advantage Plan in the provision of Community Supports.

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

M. Short-term post-hospitalization housing and recuperative care, as described in Exhibit A, Attachment III, Subsection 4.5.2 (*Optional Community Supports*), and Transitional Rent, as described in Exhibit A, Attachment III, Subsection 4.5.3 (*Transitional Rent*), are collectively referred to as "room and board" services. In accordance with California Medicaid Section 1115 Demonstration Projects, Contractor must ensure coverage of room and board services do not exceed the following caps:

1) Contractor must ensure a Member does not receive more than a combined six months of room and board services during any rolling 12-month period ("global cap" on room and board). Contractor must count the rolling 12-month period starting from the Member's first date of utilization of a room and board service. Contractor must track Member utilization in days and cap coverage to 182 combined days of room and board services in any rolling 12-month period.

2) Contractor must ensure a Member's household does not receive more than six months of Transitional Rent per Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) demonstration period.

3) Contractor must ensure a Member does not receive more than six months of short-term post-hospitalization housing per rolling 12-month period.

4) Contractor must ensure a Member does not receive more than six months of recuperative care per rolling 12-month period.

4.5.2 Optional Community Supports

A. Contractor may choose to offer Members one or more of the following pre-approved Community Supports, made effective January 1, 2022, and any subsequent Community Supports additions pre-approved by DHCS, in each county.

1) Housing transition navigation services

a. Housing transition navigation services assist Members with finding, applying for, and obtaining housing through supports such as a housing assessment, individualized planning, application assistance, and landlord engagement.

b. Members must meet at least one of the following sets of eligibility criteria (i, ii, or iii):

i. Members who meet the definition of “homeless” or “at risk of homelessness” as set forth in this Section and who meet at least one of the following sets of criteria (a, b, c, d, or e):

a. Meet the access criteria for SMHS;

b. Meet the access criteria for DMC or DMC-ODS;

c. Have one or more serious chronic physical health conditions;

d. Have one or more physical, intellectual, or developmental disabilities; or

e. Members who are pregnant up through 12 months postpartum.

ii. Members who are determined eligible for Transitional Rent, as detailed in Exhibit A, Attachment III, Subsection 4.5.3 *(Transitional Rent*). These individuals are automatically eligible for housing transitioning navigation services.

iii. Members who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless coordinated entry system or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization, or requiring residential services because of a substance use disorder (SUD) and/or is exiting incarceration.

c) Housing transition navigation services may serve as an immediate alternative to a California Medicaid State Plan covered service or setting, or as a replacement over a longer timeframe. Housing transition navigation services may potentially substitute the following California Medicaid State Plan covered services or settings: emergency department services, emergency transport services, inpatient services, outpatient hospital services, outpatient mental health, rehabilitation center outpatient services, Skilled Nursing Facility (SNF) services, and transitional inpatient care services.

d) Contractor must document the Encounter for the housing transition navigation services rendered using the standard Healthcare Common Procedure Coding System (HCPCS) code(s) and associated modifier(s) set by the State, H0043 U6 and H2016 U6.

e) Contractor must ensure coverage of housing transition navigation services is provided in accordance with Member rights and protections as detailed in 42 CFR section 438.3(e)(2).

2) Housing deposits

a) Housing deposits assist with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a Member to establish a basic household, such as security deposits, utility set up fees/deposits, or service access and utility arrearages. Housing deposits do not include the provision of room and board or payment of rental assistance. Housing deposits are available once per California Advancing and Innovating Medi-Cal (CalAIM) demonstration period. Housing deposits can be approved one additional time per CalAIM demonstration period with documentation as to what conditions have changed to demonstrate why providing housing deposits would be more successful on the second attempt.

b) Members must meet at least one of the following sets of eligibility criteria (i, ii, or iii):

i. Members who meet the definition of “homeless” or “at risk of homelessness” as set forth in this Section and

meet at least one of the following sets of criteria (a, b, c, d, or e):

a. Meet the access criteria for SMHS;

b. Meet the access criteria for DMC or DMC-ODS;

c. Have one or more serious chronic physical health conditions;

d. Have one or more physical, intellectual, or developmental disabilities; or

e. Are pregnant up through 12 months postpartum.

i. Members who are determined eligible for Transitional Rent, as detailed in Exhibit A, Attachment III, Subsection 4.5.3 *(Transitional Rent*). These individuals are automatically eligible for housing deposits.

iii. Members who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless coordinated entry system or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services because of a SUD and/or is exiting incarceration.

c) Housing deposits may serve as an immediate alternative to a California Medicaid State Plan covered service or setting, or as a replacement over a longer timeframe. Housing deposits may potentially substitute the following California Medicaid State Plan covered services or settings: emergency department services, emergency transport services, inpatient services, outpatient hospital services, outpatient mental health, rehabilitation center outpatient services, SNF services, and transitional inpatient care services.

d) Contractor must document the Encounter for housing deposit services rendered using the standard HCPCS

code(s) and associated modifier(s) set by the State, H0044 U2.

e) Contractor must ensure coverage of housing deposits is provided in accordance with Member rights and protections as detailed in 42 CFR section 438.3(e)(2).

f) Contractor must not require that Members receive housing transition navigation services to be eligible for housing deposits.

3) Housing tenancy and sustaining services

a) Housing tenancy and sustaining services provide support to Members in maintaining a safe and stable tenancy once housing is secured. Support may include education on tenant and landlord rights and responsibilities, reducing the risk of eviction, coordinating updates to housing support and crisis plans, and assistance with lease compliance.

b) Members must meet at least one of the following sets of eligibility criteria (i, ii, or iii):

i. Members who meet the definition of “homeless” or “at risk of homelessness” as set forth in this Section and meet at least one of the following sets of criteria (a, b, c, d, or e):

a. Meet the access criteria for SMHS;

b. Meet the access criteria for DMC or DMC-ODS;

c. Have one or more serious chronic physical health conditions;

d. Have one or more physical, intellectual, or developmental disabilities; or

e. Are pregnant up through 12 months postpartum.

ii. Members who are determined eligible for Transitional Rent, as detailed in Exhibit A, Attachment III, Subsection 4.5.3 (*Transitional Rent*). These

individuals are automatically eligible for housing tenancy and sustaining services.

iii. Members who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless coordinated entry system or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services because of a SUD and/or is exiting incarceration.

c) Housing tenancy and sustaining services may serve as an immediate alternative to a California Medicaid State Plan covered service or setting, or as a replacement over a longer timeframe. Housing tenancy and sustaining services may potentially substitute the following California Medicaid State Plan covered services or settings: emergency department visit, emergency transport services, inpatient services, outpatient hospital services, outpatient mental health, rehabilitation center outpatient services, SNF services, and transitional inpatient care services.

d) Contractor must document the Encounter for the housing tenancy and sustaining services rendered using the standard HCPCS code(s) and associated modifier(s) set by the State, T2040 U6, T2050 U6, T2041 U6, and T2051 U6.

e) Contractor must ensure coverage of housing tenancy and sustaining services is provided in accordance with Member rights and protections as detailed in 42 CFR section 438.3(e)(2).

4) Short-term post-hospitalization housing

a) Short-term post-hospitalization housing provides Members with the opportunity to continue their medical, psychiatric, or SUD recovery immediately after exiting an inpatient acute, psychiatric, or chemical dependency and recovery hospital; residential SUD treatment or recovery facility; residential mental health treatment facility; correctional facility; nursing facility; or recuperative care facility, and to avoid further utilization of California Medicaid State Plan covered services or settings. Short-term post-hospitalization housing must not

exceed a duration of six months per rolling 12-month period and is subject to the six-month global cap on room and board services set forth in Exhibit A, Attachment III, Subsection 4.5.1.L (*Contractor's Responsibility for Administration of Community Supports*).

b) To receive short-term post-hospitalization services, Members must meet **all** of the following sets of eligibility criteria (i, ii, iii, and iv):

i. Exiting an institution, which includes recuperative care facilities (including facilities covered under community support recuperative care or other facilities that are not Medi-Cal Providers), inpatient hospitals (either acute or psychiatric, or chemical dependency and recovery hospitals), residential SUD or mental health treatment facility, correctional facility, or nursing facility;

ii. Meet the definition of "homeless" or "at risk of homelessness" as set forth in this Section;

iii. Meet at least one of the following sets of criteria (a, b, c, or d):

a. Are receiving ECM;

b. Have one or more serious chronic conditions;

c. Have a SMI; or

d. Are at risk of institutionalization or requiring residential services because of a SUD; and

iv. Have ongoing physical or behavioral health needs as determined by a qualified health professional that would otherwise require continued institutional care if not for the receipt of short-term post-hospitalization housing.

c) Short-term post-hospitalization housing services may serve as an immediate alternative to a California Medicaid State Plan covered service or setting, or as a replacement over a longer timeframe. Short-term post-hospitalization housing services may potentially substitute the following California

Medicaid State Plan covered services or settings: emergency department services, emergency transport services, inpatient services, outpatient hospital services, post-acute care, and SNF services.

d) Contractor must document the Encounter for the short-term post-hospitalization housing services rendered using the standard HCPCS code(s) and associated modifier(s) set by the State, H0043 U3 and H0044 U3.

5) Recuperative care (medical respite)

a) Recuperative care, also referred to as medical respite care, is short-term residential care for Members who need to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable living environment. At a minimum, the service includes interim housing with a bed and meals and ongoing monitoring of the individual's ongoing medical or behavioral health condition. Recuperative care must not exceed a duration of six months per rolling 12-month period and is subject to the six-month global cap on room and board services set forth in Exhibit A, Attachment III, Subsection 4.5.1.L (*Contractor's Responsibility for Administration of Community Supports*). This support does not include funding for building modification or building rehabilitation.

b) Members must meet **both** of the following eligibility criteria (i and ii):

i. Require recovery in order to heal from an injury or illness; and

ii. Meet the definition of "homeless" or "at risk of homelessness" as set forth in this Section.

c) Recuperative care may serve as an immediate alternative to a California Medicaid State Plan covered service or setting, or as a replacement over a longer timeframe. Recuperative care may potentially substitute the following California Medicaid State Plan covered services or settings: emergency department services, emergency transport services, inpatient services, outpatient hospital services, post-acute care, and SNF services.

d) Contractor must document the Encounter for the recuperative care rendered using the standard HCPCS code(s) and associated modifier(s) set by the State, T2033 U6.

6) Respite services

a) Respite services are provided to caregivers of Members who require intermittent temporary supervision. The services are provided on a short-term basis because of the absence or need for relief of those Members who normally care for or supervise them and are non-medical in nature. Respite services may attend to the Member's basic self-help needs and other activities of daily living (ADL). In the home setting, these services, in combination with any direct care services the Member is receiving, may not exceed 24 hours per day of care. The service limit is up to 336 hours per calendar year. The service is inclusive of all in-home and in-facility services. Respite should be made available when it is useful and necessary to maintain a person in their own home and to preempt caregiver burnout to avoid institutional services for which the Contractor is responsible. Contractor can authorize exceptions to the 336 hour per calendar year limit when the caregiver experiences an episode, including medical treatment and hospitalization, that leaves a Member without their caregiver. This service is only to avoid placements for which Contractor would be responsible.

b) Members must meet at least one of the following eligibility criteria (i, ii, iii, iv, or v):

i. Members who live in the community and are compromised in their ADLs and are therefore dependent upon a qualified caregiver who provides most of their support, and who require caregiver relief to avoid institutional placement;

ii. Children who previously were covered for respite services under the pediatrics palliative care waiver;

iii. Foster care program beneficiaries;

iv. Members enrolled in either CCS or the Genetically Handicapped Persons Program (GHPP); or

v. Members with Complex Care Needs, which means the multifaceted health and social support requirements of Members who face significant barriers to achieving and maintaining health and stability. This includes individuals with multiple chronic conditions, functional impairments, behavioral health challenges, or those requiring extensive care coordination due to social determinants of health.

c) Respite services may serve as an immediate alternative to a California Medicaid State Plan covered service or setting, or as a replacement over a longer timeframe. Respite services may potentially substitute the following California Medicaid State Plan covered services or settings: home health agency, home health aide, Intermediate Care Facility (ICF) services, ICF services for the developmentally disabled, ICF services for the developmentally disabled - habilitative, personal care services, SNF stays, inpatient psychiatric facility stays, and psychiatric residential treatment facilities.

d) Contractor must document the Encounter for the respite services rendered using the standard HCPCS code(s) and associated modifier(s) set by the State, H0045 U6, S5151 U6, and S9125 U6.

e) Contractor must ensure coverage of Respite Services is provided in accordance with Member rights and protections as detailed in 42 CFR section 438.3(e)(2).

7) Day habilitation programs

a) Day habilitation programs are provided in a Member's home or an out-of-home, non-facility setting. The programs are designed to assist the Member in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the Member's natural environment. These services include the use of public transportation and daily living skills (cooking, cleaning, shopping, and money management).

b) Members must meet at least one of the following eligibility criteria (i, ii, or iii):

i. Members who meet the definition of "homeless" as set forth in this Section;

ii. Members who exited homelessness and entered housing in the last 24 months; or

iii. Members who are “at risk of homelessness” as set forth in this Section or institutionalization whose housing stability could be improved through participation in a day habilitation program.

c) Day habilitation programs may serve as an immediate alternative to a California Medicaid State Plan covered service or setting, or as a replacement over a longer timeframe. Day habilitation programs may potentially substitute the following California Medicaid State Plan covered services or settings: emergency department services, occupational therapy, outpatient hospital services, outpatient mental health, rehabilitation center outpatient services, and targeted case management services.

d) Contractor must document the Encounter for the day habilitation program services rendered using the standard HCPCS code(s) and associated modifier(s) set by the State T2012 U6, T2014 U6, T2018 U6, T2020 U6, H2014 U6, H2038 U6, H2024 U6, and H2026 U6.

e) Contractor must ensure coverage of day habilitation program is provided in accordance with Member rights and protections as detailed in 42 CFR section 438.3(e)(2).

8) Assisted living facility transitions

a) Assisted living facility transitions, formerly “nursing facility transition / diversion services,” assist Members with transitioning to and living in an assisted living facility and avoiding institutionalization when possible. This service includes two components. One component provides time-limited transition services and expenses such as assessing a Member’s housing needs and presenting options, assisting in securing a facility residence, assessing the service needs of the Member to determine if the Member needs enhanced services onsite, and coordinating their move. The second component provides ongoing assisted living services, such as support with ADLs and instrumental ADLs (IADLs), companion services, medication administration and oversight, and 24-hour direct care staff at the assisted living facility to meet unpredictable needs in a way that promotes

maximum dignity and independence, and to provide supervision, safety, and security. Contractor may not limit their offering of this service to only one component and must offer both to the extent that they are appropriate for the Member. Room and board expenses are not included in this service.

b) Members must meet one of the following eligibility criteria (i or ii):

i. Members residing in a nursing facility who:

a. Have resided 60 or more days in a nursing facility; and

b. Are willing to live in an assisted living setting as an alternative to a nursing facility; and

c. Are able to reside safely in an assisted living facility.

ii. Members residing in the community who:

a. Are interested in remaining in the community; and

b. Are willing and able to reside safely in an assisted living facility; and

c. Meet the minimum criteria to receive nursing facility level of care services and, in lieu of going into a facility, choose to remain in the community and continue to receive medically necessary nursing facility level of care services at an assisted living facility.

c) Assisted living facility transition services may serve as an immediate alternative to a California Medicaid State Plan covered service or setting, or as a replacement over a longer timeframe. Assisted living facility transitions services may potentially substitute the following California Medicaid State Plan services or settings: emergency transport services, inpatient services, ICF services, ICF services for the developmentally disabled, ICF services for the developmentally disabled - habilitative, SNF stay, and specialized rehabilitative services in SNFs and ICFs.

d) Contractor must document the Encounter assisted living facility transition services rendered using the standard HCPCS code(s) and associated modifier(s) set by the State, T2038 U4 and H2022 U5.

e) Contractor must ensure coverage of assisted living facility transition services is provided in accordance with Member rights and protections as detailed in 42 CFR section 438.3(e)(2).

9) Community or home transition services

a) Community or home transition services, formerly known as "community transition services/nursing facility transition to a home," support Members with transitional care coordination from a licensed facility to a living arrangement in a private residence or public subsidized housing where the Member is responsible for identifying funding for their living expenses. This service also covers set-up expenses necessary for a Member to establish a basic household, such as security deposits and utility set-up fees. Non-recurring set-up expenses are payable up to a total lifetime maximum amount of $7,500. The transitional coordination cost is excluded from this total lifetime maximum. These services do not include monthly rental or mortgage expenses, food, regular utility charges, or household appliances or items that are intended for purely diversionary or recreational purposes.

b) Members must meet all of the following eligibility criteria (i, ii, iii, and iv):

i. Are currently receiving medically necessary nursing facility level of care services and, in lieu of remaining in the nursing facility or recuperative care setting, are choosing to transition home and continue to receive medically necessary nursing facility level of care services;

ii. Have lived 60+ days in a nursing home and/or recuperative care setting;

iii. Are interested in moving back to the community; and

iv. Are able to reside safely in the community with appropriate and cost-effective supports and services.

c) Community or home transition services may serve as an immediate alternative to a California Medicaid State Plan covered service or setting, or as a replacement over a longer timeframe. Community or home transition services may potentially substitute the following California Medicaid State Plan covered services or settings: emergency transport services, inpatient services, ICF services, ICF services for the developmentally disabled, ICF services for the developmentally disabled - habilitative, ICF services for the developmentally disabled - nursing, SNF stay, specialized rehabilitative services in SNFs and ICFs.

d) Contractor must document the Encounter for the community or home transition services using the standard HCPCS code(s) and associated modifier(s) set by the State, T2038 U5.

e) Contractor must ensure coverage of community or home transition services is provided in accordance with Member rights and protections as detailed in 42 CFR section 438.3(e)(2).

10) Personal care and homemaker services

a) Personal care and homemaker services (PCHS) are for Members who need assistance with ADLs such as bathing, dressing, toileting, ambulation, or feeding. PCHS can also include assistance with IADLs, such as meal preparation, grocery shopping, and money management. This service cannot be utilized as a substitute for referring to the In-Home Supportive Services (IHSS) program. Members must be referred to the IHSS program when they meet the referral criteria. PCHS can be utilized during the IHSS application process, including during any waiting period after a referral has been made. PCHS may also be utilized in addition to any approved county IHSS hours when additional support is required, including when IHSS benefits are exhausted. For Members who are ineligible for IHSS, PCHS can be put in place to help prevent a short-term stay in a SNF.

b) Members must meet at least one of the following eligibility criteria (i, ii, or iii):

i. Members at risk for hospitalization or institutionalization in a nursing facility;

ii. Members with functional deficits and no other adequate support system; or

iii. Members approved for IHSS. IHSS eligibility criteria can be found at: http://www.cdss.ca.gov/In-Home-Supportive-Services.

c) PCHS may serve as an immediate alternative to a California Medicaid State Plan covered service or setting, or as a replacement over a longer timeframe. PCHS may potentially substitute the following California Medicaid State Plan covered services or settings: home health agency services, home health aide services, inpatient services, ICF services, ICF services for the developmentally disabled, ICF services for the developmentally disabled - habilitative, SNF stay, and specialized rehabilitative services in SNFs and ICFs.

d) Contractor must document the Encounter for the PCHS rendered using the standard HCPCS code(s) and associated modifier(s) set by the State, S5130 U6 and T1019 U6.

e) Contractor must ensure coverage of PCHS is provided in accordance with Member rights and protections as detailed in 42 CFR section 438.3(e)(2).

11) Environmental accessibility adaptations

a) Environmental accessibility adaptations are physical adaptations to a home that are necessary to ensure the health, welfare, and safety of the Member, or enable the Member to function with greater independence in the home, without which the Member would require institutionalization. These services include ramps and grab-bars to assist Members in accessing the home and doorway widening for Members who require a wheelchair

b) Environmental accessibility adaptations are payable up to a total lifetime maximum of $7,500. The only exceptions to the $7,500 total maximum are if:

i. The Member’s place of residence changes; or

ii. The Member's condition has changed so significantly that additional modifications are necessary to ensure the health, welfare, and safety of the Member, or are necessary to enable the Member to function with greater independence in the home and avoid institutionalization or hospitalization.

c) Members at risk for institutionalization in a nursing facility are eligible for environmental accessibility adaptations.

d) Environmental accessibility adaptations may serve as an immediate alternative to a California Medicaid State Plan covered service or setting, or as a replacement over a longer timeframe. Environmental accessibility adaptions may potentially substitute the following California Medicaid State Plan covered services or settings: emergency transport services, home health agency services, home health aide services, inpatient services, ICF services, ICF services for the developmentally disabled, ICF services for the developmentally disabled - habilitative, personal care services, SNF stay, and specialized rehabilitative services in SNFs and ICFs.

e) Contractor must document the Encounter for the environmental accessibility adaptations rendered using the standard HCPCS code(s) and associated modifier(s) set by the State, S5165 U6.

f) Contractor must ensure coverage of environmental accessibility adaptations is provided in accordance with Member rights and protections as detailed in 42 CFR section 438.3(e)(2).

12) Medically tailored meals **/** medically supportive food

a) Medically tailored meals / medically supportive foods are nutrition interventions to improve the health outcomes of Members. In addition to medically tailored meals, these services may also include medically tailored groceries, medically supportive groceries, food pharmacies, produce prescriptions, healthy food vouchers, or nutrition education (when paired with direct food assistance). Members can receive up to two meals per day and may be authorized for up to 12 weeks and may be reauthorized thereafter if Medically Necessary. The meals, food, and nutrition education provided through this service must be designed to

address or support the Member's eligible nutrition-sensitive health condition. Contractor must monitor and oversee the quality and safety of medically tailored meals / medically supportive food interventions and providers.

b) To be eligible for medically tailored meals / medically supportive foods, Members must have chronic or other serious health conditions that are nutrition-sensitive, including but not limited to: cancer(s), cardiovascular disorders, chronic kidney disease, chronic lung disorders or other pulmonary conditions such as asthma/chronic obstructive pulmonary disease (COPD), heart failure, diabetes or other metabolic conditions, elevated lead levels, end-stage renal disease, high cholesterol, human immunodeficiency virus, hypertension, liver disease, dyslipidemia, fatty liver, malnutrition, obesity, stroke, gastrointestinal disorders, gestational diabetes, high risk perinatal conditions, and chronic or disabling mental/behavioral health disorders.

c) Medically tailored meals / medically supportive foods may serve as an immediate alternative to a California Medicaid State Plan covered service or setting, or as a replacement over a longer timeframe. Medically tailored meals / medically supportive foods may potentially substitute the following California Medicaid State Plan covered services or settings: emergency department services, emergency transport services, home health agency services, home health aide services, inpatient services, outpatient hospital services, and personal care services.

d) Contractor must document the Encounter for the medically tailored meals / medically supportive food services rendered using the standard HCPCS code(s) and associated modifier(s) set by the State, S5170 U6, S9470 U6, and S9977 U6.

e) Contractor must ensure coverage of medically tailored meals / medically supportive food is provided in accordance with Member rights and protections as detailed in 42 CFR section 438.3(e)(2).

13) Sobering centers

a) Sobering centers are alternative destinations for Members who are found to be publicly intoxicated (due to alcohol or other drugs) and would otherwise be transported to the emergency department or jail. Sobering centers provide these Members with a safe, supportive environment to become sober and receive support such as rehydration and food service and treatment for nausea. This service is covered for a duration of less than 24 hours.

b) Members must meet all of the following sets of eligibility criteria (i, ii, and iii):

i) Are age 18 or older;

ii) Are intoxicated but conscious, cooperative, able to walk, are nonviolent, and free from any medical distress (including life threatening withdrawal symptoms or apparent underlying symptoms); and

iii) Who would otherwise be transported to the emergency department or a jail, or who presented at an emergency department and are appropriate to be diverted to a sobering center.

c) Sobering centers may serve as an immediate alternative to a California Medicaid State Plan covered service or setting, or as a replacement over a longer timeframe. Sobering centers may potentially substitute the following California Medicaid State Plan covered services or settings: emergency department services, inpatient services, and emergency transport services.

d) Contractor must document the Encounter for the sobering center services rendered using the standard HCPCS code(s) and associated modifier(s) set by the State, H0014 U6.

e) Contractor must ensure coverage of sobering centers is provided in accordance with Member rights and protections as detailed in 42 CFR section 438.3(e)(2).

14) Asthma remediation

a) Asthma remediation services are physical modifications to a home environment that are necessary to ensure the health, welfare, and safety of Members, or enable Members to function in the home, and without which acute asthma

episodes could result in the need for emergency services and hospitalization. These services include minor mold removal and remediation services, ventilation improvements, and allergen impermeable mattresses and pillow dustcovers.

b) Asthma remediation services are payable up to a total lifetime maximum of $7,500. The only exceptions to the $7,500 total maximum is if the Member's condition has changed so significantly that additional modifications:

i) Are necessary to ensure the health, welfare, and safety of the Member; or

ii) Are necessary to enable the Member to function with greater independence in the home and avoid institutionalization or hospitalization.

c) Eligible Members are those with poorly controlled asthma (as determined by an emergency department visit or hospitalization, two sick or urgent care visits in the past 12 months, or a score of 19 or lower on the asthma control test) for whom a licensed health care provider has documented that the service will likely avoid asthma-related hospitalizations, emergency department visits, or other high-cost services.

d) Asthma remediation may serve as an immediate alternative to a California Medicaid State Plan covered service or setting, or as a replacement over a longer timeframe. Asthma remediation may potentially substitute the following California Medicaid State Plan covered services or settings: asthma-related Primary Care and specialty visits, emergency department services, home health aide, home health agency, inpatient stay, outpatient hospital services, and personal care services.

e) Contractor must document the Encounter for the asthma remediation services rendered using the standard HCPCS code(s) and associated modifier(s) set by the State, S5165 U5.

B. Contractor must ensure Community Supports are provided in accordance with APLs or other guidance.

C. Contractor must ensure Community Supports are provided to Members in a timely manner, and must develop policies and procedures outlining its

approach to managing Community Supports Provider shortages or other barriers to ensure timely provision of Community Supports.

D. Contractor may discontinue offering Community Supports annually with notice to DHCS at least 90 calendar days prior to the discontinuation date.

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

E. At least 30 calendar days before discontinuing one or more Community Supports, Contractor must notify impacted Members of the following:

1) The change and timing of discontinuation, and

2) The procedures that will be used to ensure completion of the authorized Community Supports or a transition into other comparable Medically Necessary services.

4.5.3 Transitional Rent

A. Transitional Rent provides Members who are experiencing homelessness or at risk of homelessness with up to six months of rental assistance in allowable settings, and storage fees, amenity fees, and/or landlord-paid utilities that are charged as part of the rental assistance payment. Transitional Rent must not exceed a duration of six months per household per BH-CONNECT demonstration period. Transitional Rent is also subject to the six-month global cap on room and board services as set forth in Exhibit A, Attachment III, Subsection 4.5.1.L (*Contractor's Responsibility for Administration of Community Supports*).

B. Transitional Rent Eligibility

1) Members must meet all of the following sets of eligibility criteria (a, b, and c):

a) Members who meet the definition of "homeless" or "at risk of homelessness" as set forth in this Section.

b) Members must meet at least one of the following sets of clinical risk factor criteria (i, ii, iii, iv or v):

i. Meet the access criteria for SMHS;

ii. Meet the access criteria for DMC or DMC-ODS;

iii. Have one or more serious chronic physical health conditions;

iv. Have one or more physical, intellectual, or developmental disabilities; or

v. Members who are pregnant up through twelve months postpartum.

c) Members must meet at least one of the following sets of criteria (i, ii, iii, or iv):

i. Members within specified transitioning populations as indicated in this provision, to the extent authorization for Transitional Rent occurs within 182 days of the transitioning event (e.g., date of discharge, date of release):

a. Transitioning out of an institutional or congregate residential setting, including but not limited to, an inpatient hospital stay, an inpatient or residential SUD treatment facility, an inpatient or residential mental health facility, or nursing facility;

b. Transitioning out of a state prison, county jail, youth correctional facility, or other state, local, or federal penal setting where they have been in custody and held involuntarily through operation of law enforcement authorities;

c. Transitioning out of transitional housing, rapid rehousing, a domestic violence shelter or domestic violence housing, a homeless shelter, or other interim housing;

d. Transitioning out of short-term post-hospitalization housing or recuperative care, whether the stay was covered by a Medi-Cal managed care plan, or another source;

ii. Members up to age 26, having been in foster care on or after turning age 18, either in California or in another state;

iii. Members or families with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground (as provided in subparagraph (1)(i) of the definition of "homeless" at 24 CFR section 91.5); or

iv. Members eligible for Full Service Partnership (FSP), a comprehensive behavioral health program for individuals living with significant mental health and/or co-occurring substance use conditions that have demonstrated a need for intensive wraparound services.

a. Until July 1, 2026, the eligibility criteria for FSP are set forth in 9 CCR section 3620.05 and require a significant mental health condition as described in W&I section 5600.3 and the presence of at least one qualifying risk factor (as identified in 9 CCR section 3620.05), such as experiencing or a risk of homelessness.

b. Under the criteria that will take effect on July 1, 2026, as set forth in W&I section 5887(d), to be eligible for FSP a person 25 and under must (1) meet the criteria for a mental health condition specified in W&I section 14184.402(d), notwithstanding the age limitations provided therein, or have an SUD as defined in W&I section 5891.5(c) and (2) be in one of the priority populations identified in W&I section 5892(d), which includes those who are experiencing or at risk of homelessness, among other groups. For those 26 and over, the eligibility requirements are the same as for those 25 and under except that the criteria for a qualifying mental health condition are set forth in W&I section 14184.402(c).

C. Transitional Rent Populations of Focus

1) Contractor may elect to offer Transitional Rent to one or more of the DHCS-determined Transitional Rent Populations of Focus (POFs). Contractor must not adopt more narrowly defined eligible populations than that determined by DHCS.

2) Starting January 1, 2026, Contractor must offer Transitional Rent to the DHCS-determined Behavioral Health POF in each county it serves.

3) If Contractor elects to offer Transitional Rent to one or more Transitional Rent POFs, Contractor need not offer the Transitional Rent POF in each county it serves. Contractor must report to DHCS the counties in which it intends to offer the Transitional Rent POF. Contractor must continue to cover Transitional Rent for any POFs it elects to cover for the duration of the BH-CONNECT demonstration period.

4) Contractor must list all Transitional Rent POFs it offers in its Transitional Rent Model of Care (MOC) template and Transitional Rent MOC amendments.

D. Contractor must document the Encounter for Transitional Rent rendered using the standard HCPCS code(s) and associated modifier(s) set by the State.

E. Transitional Rent Service

1) Contractor must not exclude coverage of any specific allowable setting.

2) Contractor must ensure Community Supports Providers of Transitional Rent conduct a basic unit or setting inspection to verify the setting is compliant with applicable United States Department of Housing and Urban Development (HUD) quality standards or is habitable as defined by State law. An attestation of compliance must be submitted by the Community Supports Providers of Transitional Rent to the Contractor as a condition of authorization.

3) Contractor must ensure the Transitional Rent setting meets minimum quality standards.

F. Contractor must ensure Transitional Rent is provided in accordance with APLs or other guidance.

G. Contractor must ensure Transitional Rent is provided to Members in a timely manner and must develop policies and procedures outlining its approach to managing Community Supports Providers of Transitional Rent shortages or other barriers to ensure timely provision of Transitional Rent.

H. Contractor must contract with a network of Community Supports Providers of Transitional Rent to administer the Transitional Rent service, rather than administer payments directly to landlords.

4.5.4 Community Supports Providers

A. Community Supports Providers are entities that Contractor has determined can provide Community Supports to eligible Members in an effective manner consistent with culturally and linguistically appropriate care, as outlined in Exhibit A, Attachment III, Subsection 5.2.11 (*Cultural and Linguistic Programs and Committees*).

B. Contractor must enter into Network Provider Agreements, Subcontractor Agreements, or Downstream Subcontractor Agreements, as appropriate, with Community Supports Providers for the delivery of Community Supports elected by Contractor.

C. Contractor must ensure all Community Supports Providers for whom a State-level Enrollment pathway exists enroll in Medi-Cal, pursuant to relevant APLs, including APL 22-013. If APL 22-013 does not apply to a Community Supports Provider, Contractor must have a process for verifying qualifications and experience of Community Supports Providers, which must extend to individuals employed by or delivering services on behalf of the Community Supports Provider. Contractor must ensure that all Community Supports Providers meet the capabilities and standards required to be a Community Supports Provider.

D. In accordance with Exhibit A, Attachment III, Subsection 4.5.10 (*Data System Requirements and Data Sharing to Support Community Supports*), Contractor must support Community Supports Provider access to systems and processes allowing them to do the following, at a minimum:

1) Obtain and document Member Information including eligibility, Community Supports authorization status, Member authorization for data sharing (to the extent required by law), and other relevant demographic and administrative information; and

2) Support Community Supports Provider notification to Contractor, ECM Providers, and Member’s Primary Care Provider (PCP), as

applicable, when a referral has been fulfilled, as described in Exhibit A, Attachment III, Subsection 4.5.10 (*Data System Requirements and Data Sharing to Support Community Supports*).

E. Contractor may coordinate its approach with other Medi-Cal managed care plans offering Community Supports in the same county.

F. Contractor must prioritize contracting with locally available community-based organizations that have experience working with eligible populations and delivering the outlined Community Supports services (e.g., supportive housing providers, SNFs, medically tailored meals providers).

G. In each county Contractor serves, Contractor must offer to the county Behavioral Health department, or their designated county department or agency, a contract to serve as a Community Supports Providers of Transitional Rent. In addition, if Contractor does not contract with the county Behavioral Health department and makes arrangements for the county to serve as a "hub" or administrator on behalf of the county Behavioral Health department's network of housing providers, Contractor must make a good faith effort to contract with such providers directly.

4.5.5 Community Supports Provider Capacity

A. Contractor must develop a robust network of Community Supports Providers to deliver all elected Community Supports.

B. If Contractor is unable to offer its elected Community Supports to all eligible Members for whom it is medically appropriate and cost-effective within a particular county, Contractor must submit ongoing progress reports to DHCS in a format and manner specified by DHCS.

C. Contractor must ensure all of its Community Supports Providers have sufficient capacity to receive referrals for Community Supports and provide the agreed-upon volume of Community Supports to Members who are authorized for such services on an ongoing basis.

4.5.6 Community Supports Model of Care

A. Contractor must develop a Community Supports MOC in accordance with the DHCS-approved Community Supports MOC template. The Community Supports MOC must specify all Community Supports the Contractor offers and describe the Contractor's framework for delivering Community Supports, including a listing of its Community Supports Providers and Contractor's policies and procedures for partnering with Community Supports Providers in the provision of Community Supports. DHCS, in its

discretion, may require Contractor to develop a MOC for individual Community Supports, including Transitional Rent.

B. In developing and executing Network Provider Agreements, Subcontractor Agreements, or Downstream Subcontractor Agreements, as appropriate, with Community Supports Providers, Contractor must incorporate all requirements and policies and procedures described in its Community Supports MOC, in addition to APLs.

C. Contractor may collaborate with other Medi-Cal managed care health plans within the same county on the development of its Community Supports MOC.

D. Contractor must submit its Community Supports MOC for DHCS review and approval. Contractor must also submit to DHCS any significant changes to its Community Supports MOC for DHCS review and approval at least 60 calendar days in advance of any such occurrence of changes or updates, in accordance with DHCS policies and guidance, including APLs. Significant changes may include, but are not limited to, changes to Contractor's approach to administer or deliver Community Supports services; approved policies and procedures; and Network Provider Agreement, Subcontractor Agreement, or Downstream Subcontractor Agreement boilerplates, as appropriate.

4.5.7 Identifying Members for Community Supports

A. Contractor must utilize a variety of methods to identify Members who may benefit from Community Supports, in accordance with all applicable DCHSDHCS APLs.

B. Contractor must develop policies and procedures for Community Supports, and submit its policies and procedures to DHCS for review and approval prior to implementation as outlined in Exhibit A, Attachment III, Subsection 4.5.6 (*Community Supports Model of Care*). Contractor's policies and procedures must address the following, at a minimum:

1) How Contractor will identify Members eligible for Community Supports;

2) How Contractor will notify Members; and

3) How Contractor will receive requests to evaluate Members for Community Supports from Providers; community-based entities; and Member or Member's family, legal guardians, Authorized Representatives (ARs), and caregivers.

C. Contractor must submit all Member notices to DHCS for review and approval prior to implementation.

D. Contractor must ensure that Member identification methods for Community Supports are equitable and do not exacerbate or contribute to existing racial and ethnic disparities.

4.5.8 Authorizing Members for Community Supports and Communication of Authorization Status

A Contractor must develop and maintain policies and procedures that explain how Contractor will authorize Community Supports for eligible Members in an equitable and non-discriminatory manner. Contractor must submit its policies and procedures to DHCS for review and approval prior to implementation.

1) Contractor must develop and utilize a consistent process for ensuring that Community Supports are identified and documented as medically appropriate for the specific Member in accordance with Paragraph C of this Section.

2) Each Community Support authorization request must be considered separately for a Member. Contractor must evaluate each authorization request for medical appropriateness. Receiving one Community Support does not preclude a Member from being authorized for additional Community Supports unless a conflict is specified by DHCS.

B. Contractor must monitor and evaluate Community Supports authorizations to ensure they are equitable and non-discriminatory. Contractor must have policies and procedures in place for immediate actions that it will undertake if monitoring/evaluation processes reveal that service authorizations have had an inequitable effect.

C. Contractor must ensure that Community Supports are identified as medically appropriate for the specific Member based on both medical and social risk factors as defined in the Community Supports eligibility criteria, as determined by either Contractor's licensed clinical staff or a Network Provider, using their professional judgment. Exceptions to this requirement apply to specific Community Supports, such as asthma remediation and medically tailored meals, where medical appropriateness may be determined based on alternative criteria outlined in the respective service definitions in the Community Supports Policy Guide.

D. Contractor must develop and maintain policies and procedures to ensure Members do not experience undue delays pending the authorization process for Community Supports. If Medically Necessary, Contractor must make available the California Medicaid State Plan services that the Community Supports replace, pending authorization of the requested Community Supports.

E. Contractor must have policies and procedures for expediting the authorization of certain Community Supports for urgent needs, as appropriate, and that identify the circumstances in which any expedited authorization processes apply, in accordance with APLs and the Community Supports Policy Guide. Contractor must apply expedited authorization to the recuperative care, short-term post-hospitalization and sobering centers Community Supports.

F. When a Member has requested Community Supports, directly or through a Provider, community-based organization, or other entity, Contractor must notify the requestor and the Member of Contractor's decision regarding Community Supports authorization, in accordance with APLs. If the Member is enrolled in ECM, Contractor must ensure the ECM Provider is informed of the Community Supports authorization decision.

G. Members always retain the right to file Appeals and/or Grievances if they request one or more Community Supports offered by Contractor but were not authorized to receive the requested Community Supports.

H. For Members who sought Community Supports offered by Contractor, but were not authorized to receive the Community Supports, Contractor must submit necessary data to monitor Appeals and Grievances as well as follow its standard Grievances and Appeals process outlined in Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*) and APL 21-011.

I. Contractor must maintain policies and procedures and implement streamlined provisional authorization that enable county Behavioral Health departments contracted as Community Supports Providers of Transitional Rent to provisionally authorize and initiate Transitional Rent services.

4.5.9 Referring Members to Community Supports Providers for Community Supports

A. Contractor must develop and maintain policies and procedures to define how Community Supports Provider referrals will occur in alignment with DHCS Closed-Loop Referral (CLR) Implementation Guidance. Contractor must submit to DHCS policies and procedures for review and approval upon request from DHCS.

1) For Members enrolled in ECM, Contractor's policies and procedures must address how Contractor will work with the ECM Provider to coordinate the Community Supports referral and communicate the outcome of the referral back to the ECM Provider.

2) Contractor's policies and procedures must include expectations and procedures to ensure referrals occur in a timely manner after service authorization.

B. If the Member prefers a particular Community Supports Provider and Contractor is aware of this preference, Contractor must follow those preferences, to the extent practicable.

C. Contractor must track referrals to Community Supports Providers in alignment with DHCS CLR Implementation Guidance.

If the Member receiving Community Supports is also receiving ECM, Contractor must monitor to ensure that the ECM Provider tracks whether the Member receives the authorized service from the Community Supports Provider.

D. Contractor must not require Member authorization for Community Supports-related data sharing as a condition of initiating delivery of Community Supports, unless such authorization is required by State or federal law.

E. Contractor must develop and maintain policies and procedures for its network of Community Supports Providers to:

1) Ensure the Member agrees to receive Community Supports;

2) Where required by applicable law, ensure that Members authorize information sharing with Contractor and all others involved in the Member's care as needed to support the Member and maximize the benefits of Community Supports, in accordance with APLs, laws, and regulations;

3) Provide Contractor with Member-level records of any obtained authorization for Community Supports-related data sharing which are required by law, and to facilitate ongoing data sharing with Contractor; and

4) Obtain Member authorization to communicate electronically with the Member, Member's family, legal guardians, ARs, caregivers,

and other authorized support persons, if Contractor intends to do so.

4.5.10 Data System Requirements and Data Sharing to Support Community Supports

A. Contractor must use systems and processes capable of tracking Community Supports referrals, access to Community Supports, and Grievances and Appeals.

Contractor must support Community Supports Provider access to systems and processes allowing them to track and manage referrals for Community Supports and Member information.

B. Consistent with federal, State and, if applicable, local privacy and confidentiality laws, Contractor must ensure Community Supports Providers have access to the below as part of the referral and Provider assignment process to Community Supports Providers:

1) Demographic and administrative information confirming the referred Member's eligibility and authorization for the requested service;

2) Appropriate administrative, clinical, and social service information that Community Supports Providers might need to effectively provide the requested service; and

3) Billing information necessary to support the Community Supports Providers' ability to submit claims or invoices to Contractor.

C. Contractor must use defined federal and State standards, specifications, code sets, and terminologies when sharing physical, behavioral, social, and administrative data with Community Supports Providers and with DHCS compliance with data exchange policies and procedures, as defined by the California Health and Human Services Data Exchange Framework in accordance with H&S section 130290 and APLs, when sharing physical, behavioral, social, and administrative data with Community Supports Providers and with DHCS.

4.5.11 Contractor's Oversight of Community Supports Providers

A. Contractor must comply with all State and federal reporting requirements.

B. Contractor must perform oversight of Community Supports Providers, holding them accountable for all Community Supports requirements contained in this Contract and all applicable APLs.

C. Contractor must use all applicable APLs to develop its Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements, as appropriate, with Community Supports Providers and must incorporate all of its Community Supports Provider requirements. Contractor must submit its Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements, as appropriate, with Community Supports Providers to DHCS for review and approval in a form and manner specified by DHCS.

D. To streamline Community Supports implementation:

1) Contractor must hold Community Supports Providers responsible for the same reporting requirements as are required of Contractor by DHCS;

2) Contractor must not impose mandatory reporting requirements that are alternative or additional to those required for Encounter Data and supplemental reporting as described in Exhibit A, Attachment III, Subsection 4.5.14 (*Community Supports Reporting Requirements*); and

3) Contractor may collaborate with other Medi-Cal managed care health plans within the same county on reporting requirements and oversight.

E. Contractor must not utilize tools developed or promulgated by NCQA to perform oversight of Community Supports Providers, unless by mutual consent with the Community Supports Provider.

F. Contractor must provide Community Supports training and technical assistance to Community Supports Providers, including in-person sessions, webinars, and calls, as necessary, in addition to Network Provider training requirements, as applicable, as described in Exhibit A, Attachment III, Subsection 3.2.5 (*Network Provider Training*).

G. Contractor must not require Community Supports Providers to use a contractor-specific portal for day-to-day documentation of services. However, this prohibition does not preclude providers and Contractor from mutually agreeing to use of portals to facilitate reporting and other administrative transactions.

4.5.12 Delegation of Community Supports Administration to Network Providers, Subcontractors, or Downstream Subcontractors

A. Contractor may enter into Network Provider Agreements, Subcontractor Agreements, or Downstream Subcontractor Agreements, as appropriate,

with other entities to administer Community Supports in accordance with the following:

1) Contractor must maintain and be responsible for oversight of compliance with all Contract provisions and Covered Services, as described in Exhibit A, Attachment III, Section 3.1 (*Network Provider Agreements, Subcontractor Agreements, Downstream Subcontractor Agreements, and Contractor's Oversight Duties*);

2) Contractor must develop and maintain DHCS-approved policies and procedures to ensure Network Providers, Subcontractors, and Downstream Subcontractors meet required responsibilities and functions as described in Exhibit A, Attachment III, Subsection 3.1.4 (*Contractor's Duty to Ensure Subcontractor, Downstream Subcontractor, and Network Provider Compliance*);

3) Contractor must evaluate the prospective Network Provider's, Subcontractor's, or Downstream Subcontractor's ability to perform services as described in Exhibit A, Attachment III, Subsection 3.1.4 (*Contractor's Duty to Ensure Subcontractor, Downstream Subcontractor, and Network Provider Compliance*);

4) Contractor must ensure the Network Provider's, Subcontractor's, or Downstream Subcontractor's Community Supports Provider capacity is sufficient to serve all Populations of Focus;

5) Contractor must, as applicable, report to DHCS the names of all Subcontractors and Downstream Subcontractors by Subcontractor and Downstream Subcontractor type and service(s) provided, and identify the county or counties in which Members are served as described in Exhibit A, Attachment III, Subsection 3.1.3 (*Contractor's Duty to Disclose All Delegated Relationships and to Submit Delegation Reporting and Compliance Plan*); and

6) Contractor must make all Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements available to DHCS upon request. Such agreements must contain minimum required information specified by DHCS, including method and amount of compensation as described in Exhibit A, Attachment III, Subsection 3.1.5. (*Requirements for Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements*).

B. Contractor must ensure all Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements mirror the

requirements set forth in this Contract and APLs, as applicable to the Network Provider, Subcontractor, or Downstream Subcontractor.

C. Contractor may collaborate with its Network Providers, Subcontractors, and Downstream Subcontractors on its approach to Community Supports to minimize divergence in how the Community Supports will be implemented between Contractor and its Network Providers, Subcontractors and Downstream Subcontractors, and to ensure a streamlined, seamless experience for Community Supports Providers and Members.

4.5.13 Payment of Community Supports Providers

A. Contractor must pay contracted Community Supports Providers, including Community Supports Providers of Transitional Rent, for the provision of authorized Community Supports to Members in accordance with established Network Provider Agreements, Subcontractor Agreements, or Downstream Subcontractor Agreements between Contractor and each Community Supports Provider.

B. Contractor must utilize the claims timeline and process as described in Exhibit A, Attachment III, Subsection 3.3.5 (*Claims Processing*) to ensure timely payment of claims, bills, or invoices.

C. Contractor must identify any circumstances under which payment for Community Supports must be expedited to facilitate timely delivery of the Community Supports to the Member, such as recuperative care for a Member who is homeless and being discharged from the hospital or Transitional Rent for a Member who has secured an apartment to lease.

For such circumstances, Contractor must develop and maintain policies and procedures to ensure payment to the Community Supports Provider is expedited. Contractor must submit these policies and procedures to DHCS for review and approval prior to implementation.

D. Contractor must ensure Community Supports Providers submit a claim or invoice for rendered Community Supports.

1) If a Community Supports Provider is unable to submit a claim for Community Supports rendered, Contractor must ensure the Community Supports Provider apply the DHCS approved billing and guidance to submit invoices, located at https://www.dhcs.ca.gov/Documents/MCQMD/ECM-and-Community-Supports-Billing-and-Invoicing-Guidance.pdf.

2) Upon receipt of such an invoice, Contractor must document the Encounter for the Community Supports rendered using the standard HCPCS code(s) and associated modifier(s) set by the State.

4.5.14 Community Supports Reporting Requirements

A. In the Community Supports MOC, Contractor must include details on the Community Supports Contractor plans to offer, including which counties Community Supports will be offered and its network of Community Supports Providers.

B. After implementation of Community Supports, Contractor must submit the following data and reports to DHCS to support DHCS oversight of Community Supports:

1) Encounter Data

a) Contractor must submit all Community Supports Encounter Data to DHCS using national standard specifications and code sets to be defined by DHCS. Contractor must comply with DHCS guidance on billing and invoicing standards for Contractor to use with Community Supports Providers.

b) Contractor must submit to DHCS all Community Supports Encounter Data, including Encounter Data for Community Supports generated under Network Provider Agreements, Subcontractor Agreements, or Downstream Subcontractor Agreements.

c) In the event the Community Supports Provider is unable to submit Community Supports Encounter Data to Contractor using the national standard specifications and code sets to be defined by DHCS, Contractor must convert Community Supports Providers' invoicing and billing data into the national standard specifications and code sets, for submission to DHCS.

d) Encounter Data, when possible, must include data necessary for DHCS to stratify services by age, sex, race, ethnicity, and language spoken to inform Health Equity initiatives and efforts to mitigate Health Disparities undertaken by DHCS.

2) Quarterly Implementation Monitoring Report (QIMR)

a) Contractor must submit data on the following using an Excel-based report, called the Quality Implementation Monitoring Report (QIMR):

i. Members receiving Community Supports;

ii. Requests for Members to receive Community Supports; and

iii. Providers contracted to deliver Community Supports.

3) Monthly JavaScript Object Notation files.

C. Contractor must timely submit any related data requested by DHCS, Centers for Medicare & Medicaid Services (CMS), or an independent entity conducting an evaluation of Community Supports including, but not limited to:

1) Data to evaluate the utilization and effectiveness of Community Supports.

2) Data necessary to monitor health outcomes and quality metrics at the local and aggregate levels through timely and accurate Encounter Data and supplemental reporting on health outcomes and equity of care. When possible, metrics must be stratified by age, sex, race, ethnicity, and language spoken.

3) Data necessary to monitor Member Appeals and Grievances associated with Community Supports.

D. In the event of underperformance by Contractor in relation to its administration of Community Supports, DHCS may impose sanctions in accordance with Exhibit E, Section 1.19 (*Sanctions*).

4.5.15 Community Supports Quality and Performance Incentive Program

A. Contractor must meet all quality management and Quality Improvement requirements described in Exhibit A, Attachment III, Section 2.2 (*Quality Improvement and Health Equity Transformation Program (QIHETP)*), and any additional quality requirements for Community Supports set forth in associated guidance from DHCS.

B. Contractor may participate in a performance incentive program related to adoption of Community Supports, building infrastructure and Provider capacity for Community Supports, related health care quality and outcomes, and other performance milestones and measures, in accordance with APL 23-003 or other technical guidance.

Exhibit A, ATTACHMENT III

4.6 Member Grievance and Appeal System

4.6.1 Grievance and Appeal Program Requirements
4.6.2 Grievance Process
4.6.3 Discrimination Grievances
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4.6.6 Responsibilities in Expedited Appeals
4.6.7 State Hearings and Independent Medical Reviews
4.6.8 Continuation of Services Until Appeal and State Hearing Rights Are Exhausted
4.6.9 Grievance and Appeal Reporting and Data

4.6 Member Grievance and Appeal System

4.6.1 Grievance and Appeal Program Requirements

Contractor must have in place a Member Grievance and Appeal system that complies with 42 Code of Federal Regulations (CFR) sections 438.228 and 438.400 - 424, 28 California Code of Regulations (CCR) sections 1300.68 and 1300.68.01, and 22 CCR section 53858 for Covered Services including Contractor's selected Community Supports under 42 CFR section 438.3(e)(2) and California Medicaid Section 1115 Demonstration Projects. Contractor must follow Grievance and Appeal requirements set forth in, and use all notice templates included in, All Plan Letter (APL) 21-011. Contractor must ensure that its Grievance and Appeal system meets the following requirements:

A. Allows the Member, or a Provider or Authorized Representative (AR) with the Member's written consent, to file a Grievance, or request an Appeal with Contractor either orally or in writing.

B. Ensures timely written acknowledgement of each Grievance or Appeal, and provides a notice of resolution to the Member as quickly as the Member's health condition requires, not to exceed 30 calendar days from the date the Member makes an oral or written request to Contractor for a standard Grievance or Appeal or 72 hours for an expedited Grievance or Appeal. Contractor must notify the Member, Provider, or AR with a written resolution of the Grievance or Appeal in the Member's preferred language as required by 42 CFR sections 438.10 and 438.404, W&I section 14029.91, and 22 CCR section 53876.

C. Ensures that Members are given assistance when completing Grievance and Appeal forms and all other procedural steps. Required assistance includes, but is not limited to, providing Members with all documents Contractor relied on for its decision, and providing Auxiliary Aid and services upon request, such as translation and interpreter services, use of alternative formats for all documents Contractor relied upon for its decision, and a toll-free number with TTY/TDD and interpreter capability.

D. Ensures that the person making the final decision for the proposed resolution of a Grievance or Appeal has neither participated in any prior decisions related to the Grievance or Appeal, nor is a subordinate of someone who has participated in the prior decision. Contractor must ensure that all Grievance or Appeals related to medical Quality of Care issues be immediately submitted to Contractor's medical director for action. Contractor must ensure that the person making the decision on the Grievance or Appeal has clinical expertise in treating a Member's condition or disease when deciding:

1) An Appeal of a denial based on lack of Medical Necessity or that the service is experimental or investigational;

2) A Grievance regarding denial of a request for expedited resolution of an Appeal; and

3) Any Grievance or Appeal involving clinical issues.

E. Considers all comments, documents, records, and other information submitted by the Member, Provider, or AR, regardless of whether Contractor had the Member's additional information during the initial review.

F. Ensures that Members are given a reasonable opportunity to present evidence and testimony, and make legal or factual arguments, in person, by telephone, or in writing, in support of their Grievance or Appeal. Contactor must inform Members that they must submit additional evidence for Contractor to consider within the 30-calendar-day review timeframe for an Appeal and within the 72-hour timeframe for resolving an expedited Appeal.

G. Ensures that Notices of Appeal Resolution (NAR) be in a format and a language that, at a minimum, meets the standards set forth in 42 CFR section 438.10, W&I section 14029.91, 22 CCR section 53876, and Exhibit A, Attachment III, Subsection 5.1.3 (*Member Information*). Contractor must ensure that a notice of availability of language assistance services and auxiliary aids and services (notice of availability for short when referring to language taglines) and a nondiscrimination notice meeting the minimum requirements in APL 25-005 accompanies each Member notification, and that the nondiscrimination notice is made available, upon request or as otherwise required by law, in all of the Threshold Languages/Threshold or Concentration Standard Languages and Americans with Disabilities Act of 1990 (ADA)-compliant, accessible formats as needed by Members to effectively understand Contractor's notices.

H. Provides oral notice of the resolution of an expedited Appeal to the Member, Provider, or AR within 72 hours.

I. Provides Contractor's Grievance and Appeal policies and procedures to Network Providers, Subcontractors, and Downstream Subcontractors at the time that they enter into a Network Provider Agreement, Subcontractor Agreement, or Downstream Subcontractor Agreement. Contractor must ensure that Network Providers, Subcontractors, and Downstream Subcontractors are trained on and immediately notified of any changes to Contractor's Grievance and Appeal policies and procedures.

J. Maintains policies and procedures for compiling, aggregating, and reviewing Grievance and Appeal data for use in Contractor's Quality Improvement Strategy (QIS). Contractor must regularly analyze Grievance and Appeal data to identify, investigate, report, and act upon systemic patterns of improper service denials and other trends impacting health care access and delivery to Members. Contractor must impose necessary Corrective Action to remedy all identified deficiencies.

K. Maintains records of Grievances and Appeals in a manner accessible to DHCS and to the Centers for Medicare & Medicaid Services (CMS), upon request. Contractor must review Grievance and Appeal data and information as part of its ongoing monitoring procedures as well as for updates and revisions to its QIS. The record of each Grievance or Appeal must contain, at a minimum, all information set forth in 42 CFR section 438.416(b). Contractor must ensure that all documents and records, whether in written or electronic format, generated or obtained by Contractor in the course of responding to Adverse Benefit Determinations (ABD), Grievances, Appeals, and Independent Medical Reviews (IMRs) are retained for at least 10 years pursuant to 42 CFR section 438.3(u).

4.6.2 Grievance Process

Contractor's policies and procedures must include all required information set forth below for Grievances and the expedited review of Grievances as required under 42 CFR sections 438.402, 438.406, and 438.408; 28 CCR sections 1300.68 and 1300.68.01; and 22 CCR section 53858:

A. A policy and procedure for Members to file a Grievance with Contractor at any time to express dissatisfaction about any matter other than a notice of ABD.

B. A policy and procedure to allow Members to file a Grievance to contest Contractor's unilateral decision to extend the timeframe for resolution of an Appeal or expedited Appeal.

C. A policy and procedure to ensure that every Grievance involving clinical issues that is submitted is reported to qualified medical professionals with appropriate clinical expertise and is escalated to Contractor's medical director as needed, to ensure the Grievance is properly handled.

D. A policy and procedure to ensure that Contractor's staff monitor Grievances to identify issues that require Corrective Action. Grievances related to medical Quality of Care issues must be referred to qualified medical professionals with appropriate clinical expertise and be escalated to Contractor's medical director as needed.

E. A policy and procedure for Contractor to provide written acknowledgement to the Member within five calendar days of receipt of the Grievance. The acknowledgement letter must advise the Member that the Grievance has been received; provide the date of receipt; and provide the name, telephone number, and address of the representative who the Member, their Provider, or their AR may contact about the Grievance.

4.6.3 Discrimination Grievances

Contractor must process Discrimination Grievances as required by federal and State nondiscrimination law and DHCS policy, as stated in 45 CFR section 92.7 - 92.8, 45 CFR section 84.7, 34 CFR section 106.8, 28 CFR section 35.107, W&I section 14029.91(e)(4), and APL 25-005.

A. Contractor must designate a Discrimination Grievance coordinator responsible for ensuring compliance with federal and State nondiscrimination requirements and investigating Discrimination Grievances related to any action that would be prohibited by, or out of compliance with, federal or State nondiscrimination law.

B. Contractor must adopt and implement written policies and procedures to ensure the prompt and equitable resolution of Discrimination Grievances. Contractor must not require a Member or Potential Member to file a Discrimination Grievance with Contractor before filing with the DHCS Office of Civil Rights or the U.S. Department of Health and Human Services Office for Civil Rights.

C. Within ten calendar days of mailing a Discrimination Grievance resolution letter, Contractor must submit information regarding the Discrimination Grievance to the DHCS Office of Civil Rights, as specified in APL 25-005 to DHCS.DiscriminationGrievances@dhcs.ca.gov.

D. Contractor must inform Members on its website that Discrimination Grievances may be filed directly with the DHCS Office of Civil Rights and must include contact information for the DHCS Office of Civil Rights, as required by Exhibit A, Attachment III, Subsection 5.1.3 (*Member Information*).

4.6.4 Notice of Action

When Contractor makes an authorization decision, it must send a Notice of Action (NOA). A NOA is a notice of any action that impacts a Member’s ability to obtain Covered Services or other benefits Contractor is required to provide under this Contract. A NOA includes, but is not limited to, a notice of ABD for a requested health care service under 42 CFR sections 438.210(d) and 438.404, including requested Community Supports that Contractor has elected to cover

under 42 CFR section 438.3(e)(2) and California Medicaid Section 1115 Demonstration Projects.

Contractor's failure to render a decision and send a written NOA to the Member within the required timeframes below is considered a denial of the requested service and therefore constitutes an ABD on the date that Contractor's timeframe for approval expires, in accordance with 42 CFR section 438.404(c)(5). In cases where Contractor fails to meet the required notice timeframes, the Member may immediately request an Appeal with Contractor and Contractor must send the Member written notice of all Appeal rights.

A. Standard Authorization Requests

1) Contractor must ensure a NOA is sent when approving, denying or modifying a Provider's Prior Authorization or concurrent request for health care services (excluding pharmacy services, but including Community Supports) for a Member within the shortest applicable timeframe that is appropriate for the nature of the Member's condition, but no longer than five Working Days from Contractor's receipt of information reasonably necessary and requested by Contractor to make a determination, not to exceed 14 calendar days following Contractor's receipt of the request for service, in accordance with 42 CFR sections 438.210(d)(1) and 438.404(c)(3); and

2) Contractor must notify the requesting Provider of its authorization decision within 24 hours of the decision and send the written NOA to the Member within two Working Days in accordance with H&S section 1367.01(h)(1) and (3).

3) Contractor must send the written NOA approving, denying, or modifying the authorization request. Contractor must approve, deny, or modify the request and send the written NOA within the shortest applicable timeframe that is appropriate for the nature of the Member's condition, but no longer than five Working Days from Contractor's receipt of information reasonably necessary and requested by Contractor to make a determination, not to exceed 14 calendar days in accordance with 42 CFR sections 438.210(d)(1) and 438.404(c)(3); and

4) Contractor must send the written NOA to the Member with sufficient time to allow for continuation of benefits pursuant to 42 CFR section 438.420.

B. Expedited Authorization Requests

1) In instances where a Provider indicates, or Contractor determines, that the standard request timeframe may seriously jeopardize the Member's life; health; or ability to attain, maintain, or regain maximum function, Contractor must approve, modify, or deny a Prior Authorization or concurrent request for health care services, and send the written NOA, in a timeframe which is appropriate for the nature of the Member's condition, but no longer than 72 hours from receipt of the authorization request in accordance with 42 CFR section 438.210(d)(2) and (d)(2)(i).

2) Contractor must send the written NOA approving, denying, or modifying the authorization request. Contractor must send the written NOA to the Member with sufficient time to allow for continuation of benefits pursuant to 42 CFR section 438.420.

3) Contractor must approve, modify, or deny the request within the shortest applicable timeframe that is appropriate for the nature of the Member's condition, but no longer than 72 hours from Contractor's receipt of additional information requested by Contractor to make a determination. Contractor's written notice to the Member must be sent with sufficient time to allow the Member to request Aid Paid Pending if applicable.

C. Retrospective Review

Contractor must approve, modify, or deny a Provider's request for Retrospective Review authorization for health care services provided to a Member, and send the written NOA to the Member, within 30 calendar days from receipt of information that is reasonably necessary to make a determination.

D. Terminations, Suspensions, or Reductions

1) For terminations, suspensions, or reductions of previously authorized services, Contractor must notify Members at least ten calendar days before the date of the action pursuant to 42 CFR section 431.211, with the exception of circumstances permitted under 42 CFR sections 431.213 and 431.214.

2) For purposes of auditing, the postmark on Contractor's notice to the Member will be used to confirm compliance with all authorization request timeframes and notice requirements set forth in Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*).

E. Required Information in Contractor's NOA Informing Member of Notice of ABDs.

Contractor must ensure all NOAs informing a Member of an ABD are in writing in a format and language that, at a minimum, meets the standards set forth 42 CFR sections 438.10, 438.404, and 438.408; W&I section 14029.91; 22 CCR section 53876; and Exhibit A, Attachment III, Subsection 5.1.3 (*Member Information*), and APL 25-005, Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services. Contractor's NOA informing of an ABD must include all of the following:

1) A clear and concise explanation of the action that Contractor or its Network Provider has taken or intends to take, including a fully translated written notice with a fully translated clinical rationale for Contractor's decision at the point of each determination;

2) The reason for the action, including notification to the Member of the right to be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and any other information Contractor relied on for the decision, including clinical criteria; Medical Necessity criteria; and any processes, strategies, or evidentiary standards relied on for the decision;

3) The Member's right to request an Appeal with Contractor no later than 60 calendar days from the date on the NOA, and information on exhausting Contractor's one-level Appeal system;

4) The Member's right to an expedited Appeal if the Member's health condition requires resolution in less than 72 hours and information on how to request an expedited Appeal;

5) The Member's rights and information on the process to request a State Hearing after having exhausted Contractor's internal Appeal process and having received notice that Contractor is upholding its action. The NOA must also advise that the Member may request a State Hearing in cases where Contractor fails to send a NAR or notice of extension in response to the Appeal within 30 calendar days of the Member's request for an Appeal. This is known as Deemed Exhaustion pursuant to 42 CFR section 438.402(c)(1)(i)(A);

6) The Member's right to continue receiving Covered Services pending the resolution of the Appeal, and Contractor's obligation to continue benefits as required by 42 CFR section 438.420 and

Exhibit A, Attachment III, Subsection 4.6.8 (*Continuation of Services Until Appeal and State Hearing Rights Are Exhausted*) below; and

7) If applicable, the Member's right to request a clinical review of Contractor's action, called an IMR, from DMHC and that the Member must request an IMR before there is a final decision on their State Hearing.

F. For visually impaired Members, Contractor must provide the NOA in the Member's selected alternative format in order to be considered adequate notice. Contractor must not deny, delay, modify, limit, or terminate services or treatments without providing adequate notice within the timeframes stated in this Exhibit A, Attachment III, Subsection 4.6.4 (*Notice of Action*). In accordance with APL 25-016, Contractor must calculate the appropriate timeframe(s) for a visually impaired Member to take action from the date of receiving adequate notice in their selected alternative format, including all deadlines for Appeals.

G. Contractors are not permitted to make any changes to DHCS' NOA templates or the NOA "Your Rights" Attachment without prior review and approval from DHCS, except to insert the specific reasons for Contractor's action to the Member, as required.

4.6.5 Appeal Process

Pursuant to 42 CFR sections 438.228 and 438.400 - 424, Contractor must have an Appeal process as required below to attempt to resolve Member Appeals before the Member requests a State Hearing or an IMR. Contractor must have only one level of Appeal for Members. Upon a Member's request, Contractor must assist any Member in preparing their Appeal, which includes assisting the Member with navigating Contractor's website, providing all documents that Contractor relied on for its decision, and providing the Appeal form to the Member.

A. Following the receipt of a NOA, a Member has 60 calendar days from the date on the NOA to file a request for an Appeal either orally or in writing. The Member, or a Provider or AR acting on behalf of the Member and with the Member's written consent, may request an Appeal. Unless the Member is requesting an expedited Appeal, the date of the Member's oral or written request for an Appeal establishes the filing date for the Appeal. Contractor must resolve the Appeal within 30 calendar days of the Member's oral or written request for an Appeal.

B. If Contractor fails to send a written NOA within 30 calendar days or fails to comply with notice and language translation requirements in 42 CFR

sections 438.10, 438.404, and 438.408; W&I section 14029.91; 22 CCR section 53876; and Exhibit A, Attachment III, Subsection 5.1.3 (*Member Information*), the Member is deemed to have exhausted Contractor's internal Appeal process and may request a State Hearing pursuant to 42 CFR section 438.402(c)(1)(i)(A).

C. Contractor's NOA informing the Member of its NAR must, at a minimum, indicate whether Contractor upheld its decision on the Appeal and the date of Contractor's decision on the Appeal. For decisions not wholly in the Member's favor, Contractor's NAR must, at a minimum, include:

1) Member's right to request a State Hearing;

2) How to request a State Hearing;

3) That the Member has a right to continuation of benefits during the State Hearing, and that Contractor is obligated to continue benefits as long as the requirements of 42 CFR section 438.420 are met;

4) If applicable, the right to request an IMR or a review of Contractor's decision by DMHC, and that the IMR must be requested before there is a final State Hearing decision; and

5) The DHCS-approved "Your Rights" Attachment.

D. If Contractor reverses its decision during the Appeal, it must authorize or provide the disputed services promptly, and as expeditiously as the Member's health condition requires, but no later than 72 hours from the date it reverses the action if the disputed services were not provided during the Appeal.

E. Contractor must pay for disputed services if the Member received the disputed services while the Appeal was pending.

F. Contractor must provide the Member or AR the opportunity before and during their Appeal process to examine their case file. Contractor must provide, sufficiently in advance of the resolution timeframe and free of charge, the Member's case file, including Medical Records, clinical criteria, guidelines, and all documents and records Contractor relied on during the Appeal process for its decision. Contractor must assist any Member who requires assistance preparing their Appeal.

G. Contractor may withdraw a Grievance or Appeal upon Member request if performed in compliance with the established Grievance and Appeals processes required in this Contract and federal and State laws and regulations. Where a Grievance or Appeal was filed by a Provider or AR of

a Member, written Member consent is required for a Provider or AR to withdraw the Grievance or Appeal.

4.6.6 Responsibilities in Expedited Appeals

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

A. A Member, or a Provider or an AR with the Member's written consent, may file an expedited Appeal either orally or in writing. No additional follow-up from the Member is required. Contractor must ensure that punitive action is not taken against a Provider who requests an expedited resolution or supports a Member's Appeal.

B. Contractor must inform the Member of the limited time available for the Member to present evidence and allegations of fact or law, in person, by phone, or in writing, sufficiently in advance of the resolution timeframe.

C. Contractor must resolve an expedited Appeal as quickly as the Member's health condition requires, but no later than 72 hours from the day Contractor receives the request for an expedited Appeal.

D. Contractor must make a reasonable effort to provide oral notice of an expedited Appeal decision.

E. If Contractor denies a request for an expedited resolution of an Appeal, it must process the request for an Appeal in accordance with the standard Appeal process timeframes for resolutions and extensions as required in Exhibit A, Attachment III, Subsection 4.6.5 (*Appeal Process*).

4.6.7 State Hearings and Independent Medical Reviews

A. State Hearings

1) The Member, or a Provider or AR with the Member's written consent, may request a State Hearing:

a) After receiving a NAR confirming that Contractor has upheld its ABD, and the request is made within 120 calendar days from the date on the NAR;

b) In cases of Deemed Exhaustion, due to Contractor's failure to comply with Appeal notice and timing requirements as required by 42 CFR sections 438.10, 438.402, 438.404, 438.406, 438.408, and 438.410; W&I sections 10951 and 10951.5; and as stated in this Contract, the Member may immediately request a State Hearing. In cases of Deemed Exhaustion, Contractor must not request a dismissal of the State Hearing based on a failure to exhaust Contractor's internal Appeal process; or

c) If Contractor fails to provide Appeal notices required in 42 CFR section 438.408 to a Member with a visual impairment, in the Member's selected alternative format and within the applicable federal or State timeframes, the Member is deemed to have exhausted Contractor's internal Appeal process and may immediately request a State Hearing. In such cases, Contractor is prohibited from requesting dismissal of a State Hearing on the basis of failure to exhaust Contractor's internal Appeal process.

2) Upon request from the Member, Contractor must assist the Member with preparing for the State Hearing by providing the Member or their AR with the Member's case file, including Medical Records, other documents and records, guidelines, clinical criteria, and any new or additional evidence that Contractor relied on for its initial denial and anything Contractor considered during its internal Appeal process. This information must be provided free of charge and sufficiently in advance of the resolution timeframe.

3) Contractor must provide its statement of position for the State Hearing to the Member and to the California Department of Social Services at least two Working Days before the State Hearing.

4) Contractor must ensure that an employee familiar with the facts of the case and Contractor's basis for upholding its ABD is available to actively participate in the State Hearing by ensuring that the employee is available and prepared to present Contractor's position and be subject to cross examination at the State Hearing as required by 42 CFR sections 431.205 and 431.242 and *Goldberg v. Kelly* (1970) 397 US 254. Contractor must ensure that it provides accurate contact information for its State Hearing representative to ensure an appearance at the State Hearing via telephone or in person. Additionally, to ensure Member's right to due process during the State Hearing process, Contractor must ensure that a statement of position is timely filed with the California Department of Social Services and provided to the Member not less than two

Working Days before the hearing as required by W&I section 10952.5.

5) In cases where the State Hearing decision overturns Contractor's decision, Contractor must authorize or provide the disputed services promptly, and as expeditiously as the Member's health condition requires, but no later than 72 hours from the date Contractor receives notice that the State Hearing decision reversed Contractor's decision.

6) Contractor must pay for disputed services if the Member received the disputed services while the State Hearing was pending.

7) The parties to a State Hearing must include Contractor as well as the Member, their AR, or the representative of a deceased Member's estate.

8) Contractor must notify Members that the State must make a decision for a State Hearing within 90 calendar days of the date of the State Hearing request. For an expedited State Hearing, DHCS will take final administrative action as expeditiously as the individual's health condition requires, but no later than three Working Days after Contractor provides DHCS with the case file and information supporting its Appeal of an ABD pursuant to W&I section 10951.5. Contractor must also comply with all other requirements as required by 42 CFR sections 438.410 and 438.404(a), W&I section 14029.91(e), 22 CCR sections 53876 and 53895, and APL 21-011.

B. Contractor's Obligations for Expedited State Hearings

1) Within two Working Days of being notified by DHCS or the California Department of Social Services that a Member has filed a request for State Hearing which meets the criteria for expedited resolution, Contractor must deliver directly to the designated/appropriate California Department of Social Services administrative law judge all information and documents which either support, or which Contractor considered in connection with, the action which is the subject of the expedited State Hearing. This includes, but is not limited to, copies of the relevant Treatment Authorization Request and NOA, plus any pertinent NAR and all documents Contractor relied on for its denial, including clinical criteria and guidelines. If the NOA or NARs are not in English, Contractor must transmit fully translated copies to the California Department of Social Services along with copies of the original NOA and NARs.

2) Contractor must ensure that an employee familiar with the facts of the case and Contractor's basis for upholding its ABD is available to actively participate in the expedited State Hearing by ensuring that the employee is available and prepared to present Contractor's position during cross examination at the State Hearing as required by 42 CFR sections 431.205 and 431.242 and *Goldberg v. Kelly* (1970) 397 US 254. Contractor must ensure that it provides accurate contact information for its State Hearing representative to ensure an appearance at the Hearing via telephone or in person. Additionally, to ensure Member's right to due process during the State Hearing process, Contractor must ensure that its completed case file, including the statement of position, is timely filed with the California Department of Social Services as required by W&I section 10951.5(b)(1).

C. Independent Medical Review

1) If applicable to Contractor's plan model, Contractor must inform Members of the right to request an IMR of an action resulting in a Member request for an Appeal, or the outcome of an Appeal.

2) An IMR must be requested by the Member, or a Provider or AR with written authorization from the Member to act on the Member's behalf. Contractor must not require a Member to request an IMR before, or use one as a deterrent to, requesting a State Hearing.

3) IMRs must be conducted by the California Department of Managed Healthcare (DMHC) independently from either the Member or Contractor, and at no cost to the Member.

4) IMRs do not extend any of the time frames stated in this Contract for Appeals, and do not disrupt the continuation of Covered Services per 42 CFR section 438.420.

4.6.8 Continuation of Services Until Appeal and State Hearing Rights Are Exhausted

A. Contractor must automatically continue providing the disputed services to the Member while the Appeal and State Hearing are pending if all of the following conditions are met:

1) The Member filed their Appeal within the required timeframes set forth in 42 CFR section 438.420;

2) The Appeal involves the termination, suspension, or reduction of previously authorized Covered Services;

3) The disputed services were ordered by the Member's Provider; and

4) The period covered by the original authorization has not expired.

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

1) The Member withdraws their request for an Appeal or a State Hearing;

2) The Member fails to request a State Hearing and continuation of disputed services within ten calendar days of when the NAR was sent; or

3) The final State Hearing decision is adverse to the Member.

C. Contractor must pay for disputed services if the Member received the disputed services while the Appeal or State Hearing was pending. Contractor must ensure the Member is not billed for the continued services even if the final resolution of the Appeal, State Hearing, or IMR is adverse to the Member.

4.6.9 Grievance and Appeal Reporting and Data

A. Contractor must submit a Grievance and Appeal log to DHCS upon request for Medi-Cal Members only in the form that is required by and submitted to Department of Managed Health Care (DMHC), as set forth in 28 CCR section 1300.68(f), with additional information required by DHCS per 42 CFR section 438.416 and 22 CCR section 53858(e).

B. Contractor must submit Grievance and Appeal data to DHCS monthly as specified in Exhibit A, Attachment III, Section 2.1.5 (*Program Data Reporting)* and APL 20-017.

C. Contractor must comply with the requirements set forth in Exhibit A, Attachment III, Section 2.1 (*Management Information System*) of this Contract for the reporting of Grievance and Appeal data.

D. Contractor must maintain records of Grievances and Appeals and must have policies and procedures in place governing the review of the information as part of its ongoing QIS. Contractor must identify systemic patterns of wrongful denials and impose Corrective Action as necessary.

The records must be accurately maintained in a manner accessible to the State and available to CMS upon request. Records must include all required information set forth in 42 CFR section 438.416(b). Contractor must ensure that all documents and records, whether in a written or electronic format, generated or obtained by Contractor in the course of responding to ABDs, Grievances, Appeals, and IMRs are retained for at least 10 years pursuant to 42 CFR section 438.3(u).

Exhibit A, ATTACHMENT III

5.0 Services – Scope and Delivery

DHCS has a longstanding commitment to ensure Members have access to high-quality services. The provisions in this Article lay out DHCS expectations of Contractor for promoting access to medical, behavioral, and social services; increasing integration and collaboration across delivery systems and with local partners; and ultimately improving health outcomes.

Through the provisions in this Article, several key goals of California Advancing and Innovating Medi-Cal (CalAIM) are addressed. For example, Contractor must manage the health care needs of the Member over time through a comprehensive array of person-centered health and social services spanning all levels of intensity of care, from birth to dignified end of life. This Article also includes provisions related to Advance Directives and ensuring that Contractor informs Members of what an Advance Directive is and how to put a valid one in place. This Article contains key provisions related to information Members must receive to help them navigate the health care system including information that must be included in the Member Handbook and Provider Directory.

This Article also address access to evidence-based Behavioral Health care, with a focus on integration with physician health and earlier identification and engagement in treatment for Children, youth, and adults. Provisions included here also implement No Wrong Door policies and outline expectations that Contractor ensure Members receive timely mental health services without delay regardless of the delivery system where they seek care. Contractors are expected to ensure Members maintain treatment relationships with trusted Providers without interruption, to the extent feasible.

This Article lays out expectations for services and access to community-based Providers that provide social support including Dyadic Care Services, Doula services, and Community Health Workers (CHW). The intent for enabling access to these provider types is to improve health outcomes by meeting the Behavioral Health (including emotional health and wellbeing), and physical health needs of culturally diverse populations.

DHCS recognizes the importance of coordination and collaboration with other local partners in order to meet the needs of the whole person. Accordingly, DHCS sets forth requirements for Contractor to engage with local entities to promote Member needs for not only Medically Necessary health care services but also any supportive services as needed to treat the whole person and prevent avoidable negative health and social outcomes for individual Members to treat the whole person. This entails partnerships with Local Health Departments, Local Educational and Government Agencies, and other local programs and services including county social services departments, Child welfare departments, and justice departments. This Article also establishes oversight of

Memorandum of Understanding (MOU) requirements and requires referrals to ensure Member care is coordinated and community-based resources, including Community Supports, are availed. Beyond the MOU requirements, DHCS seeks to embed the whole person care and community-informed care approach within its Population Health Management (PHM) strategy and requires the same of Contractor. As such, this Article includes provisions requiring Contractor engagement with community representatives of diverse cultural and ethnic backgrounds to develop its PHM strategies.

To empower Members to become active participants in their care, DHCS has enhanced existing processes and created new channels for engagement for Members, families, and the community. Historically, Medi-Cal managed care plans are required to maintain a Community Advisory Committee (CAC), which serves to inform Contractor's cultural and linguistic services program. DHCS seeks to elevate the CAC by clarifying its role and member composition and prescribing Contractor's role in providing support for CAC members in order to maximize participation and involvement.

Exhibit A, ATTACHMENT III

5.1 Member Services

5.1.1 Member Rights and Responsibilities
5.1.2 Member Services Staff
5.1.3 Member Information
5.1.4 Primary Care Provider Selection
5.1.5 Notices of Action for Denial, Deferral, or Modification of Prior Authorization Requests

5.1 Member Services

5.1.1 Member Rights and Responsibilities

A. Member Rights and Responsibilities

Contractor must develop, implement, and maintain written policies and procedures that set forth the Member's rights and responsibilities and must communicate its policies to its Members, Providers, and, upon request, Potential Members.

1) Contractor's written policies and procedures must include the following Member rights:

a) To be treated with respect, giving due consideration to the Member’s right to privacy and the need to maintain confidentiality of the Member’s Protected Health Information (PHI) and private information.

b) To be provided with information about Contractor’s organization and all services available to Members.

c) To be able to choose their Primary Care Provider (PCP) within Contractor's Network unless the PCP is unavailable or is not accepting new patients.

d) To participate in decision-making regarding their health care, including the right to refuse treatment.

e) To submit Grievances, either verbally or in writing, about Contractor, Providers, care received, and any other expression of dissatisfaction not related to an Adverse Benefit Determination (ABD).

f) To request an Appeal of an ABD within 60 calendar days from the date on the Notice of Adverse Benefit Determination (NABD) and request how to continue benefits during the in-plan Appeal process through the State Hearing, when applicable.

g) To request a State Hearing, including information on the circumstances under which an expedited State Hearing is available.

h) To receive interpretation services and written translation of critical informing materials in their preferred Threshold

Language, including oral interpretation and American Sign Language.

i) To have a valid Advance Directive in place, and an explanation to Members of what an Advance Directive is.

j) To have access to family planning services and sexually transmitted disease services, from a Provider of their choice, without referral or Prior Authorization, either in or outside of Contractor's Network. To have Emergency Services provided in or outside of Contractor's Network, as required pursuant to federal law.

k) To have access to Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs) and Indian Health Care Providers (IHCP) outside of Contractor's Network, pursuant to federal law.

l) To have access to, and receive a copy of, their Medical Records, and request that they be amended or corrected, as specified in 45 Code of Regulations (CFR) sections 164.524 and 164.526.

m) To change Medi-Cal managed care plans upon request, if applicable.

n) To access Minor Consent Services.

o) To receive written Member informing materials in alternative formats, including Braille, large size print no smaller than 20 point font, accessible electronic format, and audio format, upon request and in accordance with 42 CFR section 438.10 and 45 CFR sections 84.52(d) and 92.102.

p) To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

q) To receive information on available treatment options and alternatives, presented in a manner appropriate for the Member's condition and ability to understand available treatment options and alternatives.

r) To freely exercise these Member rights without retaliation or any adverse conduct by Contractor, Subcontractors, Downstream Subcontractors, Network Providers, or the State.

2) Contractor must provide its written policies and procedures regarding Member rights and responsibilities to its staff and all Network Providers, Subcontractors, and Downstream Subcontractors. Contractor must ensure that its staff, Network Providers, Subcontractors, and Downstream Subcontractors are trained and knowledgeable on Members' rights as required under Exhibit A, Attachment III, Section 3.2 (*Provider Relations*).

B. Member's Right to Confidentiality

Contractor must have policies and procedures in place to ensure Members' rights to confidentiality of PHI and Personal Information (PI) in accordance with 45 CFR parts 160 and 164, and in accordance with Civil Code section 1798 *et seq*.

1) Contractor must ensure that all Subcontractors, Downstream Subcontractors, and Network Providers have policies and procedures in place to guard against unlawful disclosure of PHI, PI, and any other Confidential Information to any unauthorized persons or entities.

2) Contractor must inform and advise Members on the right to confidentiality of their PHI and PI. Contractor must obtain the Member's prior written authorization to release Confidential Information, unless such prior written authorization is not required by State and federal law.

C. Member's Right to Advance Directives

Contractor must have written policies and procedures to ensure Members are informed of what an Advance Directive is and how to put a valid Advance Directive in place. Contractor must have policies and procedures in place to ensure all involved in the Member's care comply with the terms of a Member's valid Advance Directive in accordance with the requirements of 42 CFR sections 422.128 and 438.3(j).

1) Contractor must ensure that its process for a Member's right to have an Advance Directive in place is included in the Member Handbook. Information in the Member Handbook must include the Member's right to be informed by Contractor of State law regarding Advance Directives, and to receive information from Contractor regarding any changes to that law. Contractor must ensure that the following statement, or similar language provided by DHCS is included:

Advance care planning for Members enrolled in Medi-Cal palliative care in accordance with All Plan Letter (APL) 18-020, must include documented discussions between a physician or other qualified healthcare professional and a patient, family member, or legally-recognized decision-maker. Counseling that takes place during these discussions addresses, but is not limited to, Advance Directives, such as Physician Orders for Life-Sustaining Treatment (POLST) forms.

2) Information on Advance Directives must comply with all State and federal law requirements and must be updated to reflect any changes to laws governing Advance Directives.

3) Contractor must ensure its Network Providers, Subcontractors, and Downstream Subcontractors are trained on complying with valid Advance Directives in accordance with 42 CFR sections 422.128 and 438.3(j).

D. Interoperability Requirements for Member Records

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

1) At a minimum, Contractor must permit third-party applications to retrieve, with the approval and at the direction of the Member, the following Member records:

a) Adjudicated claims data from Contractor, and from any Subcontractors, Downstream Subcontractors and Network Providers, including claims data and cost data that may be Appealed, or are in the process of Appeal, Provider remittances, and Member cost-sharing pertaining to such claims, within (1) Working Day after a claim is processed;

b) Encounter Data, including Encounter Data from any capitated Subcontractors, Downstream Subcontractors, and Network Providers, within one (1) Working Day after receiving the data from Providers;

c) Clinical data, including diagnoses and related codes, and laboratory test results, within one (1) Working Day after the

data is received by Contractor; and

d) Information about coverage for drugs administered in an outpatient setting as part of medical services, and updates to such information, including, if applicable, Member costs and any preferred drug list information, within one (1) Working Day after the effective date of any such information or updates to such information.

2) Contractor may deny or discontinue any third-party application's connection to an API if it reasonably determines, consistent with its security risk analysis under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Security Rule set forth in 45 CFR part 160 and 45 CFR part 164, subparts A and C, that continued access presents an unacceptable level of risk to the security of protected health information on its systems. The determination must be made using objective verifiable criteria that are applied fairly and consistently across all applications and developers, including but not limited to criteria that may rely on automated monitoring and risk mitigation tools.

E. Member Cost-Sharing Protections

1) Pursuant to The Social Security Act section 1932(b)(6) and 42 USC section 1396u-2(b)(6), Contractor and all of its Subcontractors must not hold a Member liable for any of the following:

a) Debts of Contractor in the event of Contractor's insolvency;

b) Payment for Covered Services provided by Contractor if Contractor has not received payment from DHCS, or if a Provider, under an agreement or other arrangement with Contractor, fails to receive payment from either DHCS or Contractor; or

c) When payments to a Provider that furnishes Covered Services under an agreement or other arrangement with Contractor are in excess of the amount that normally would be paid by the Member if the service had been received directly from the Contractor.

2) Contractor, including its Network Providers and Subcontractors, must not bill a Member for any Covered Services provided under this Contract. Contractor must assure that all Network Provider Agreements include requirements whereby the Member must be held harmless for charges for any Covered Services.

3) Contractor and its Network Providers are prohibited from imposing on Members cost-sharing requirements. Contractor's Subcontractor Agreements and Network Provider Agreements must specify that a Provider agrees to accept Contractor's reimbursement as payment in full for services rendered to Members.

5.1.2 Member Services Staff

A. Contractor must employ and train a sufficient number of staff knowledgeable about Contractor's policies and procedures and capable of providing information to Members or Potential Members.

B. Contractor must ensure its Member services staff are trained and educated on all contractually required services for Members including policies and procedures on the scope of services required to be offered under this Contract, how to utilize services in the Medi-Cal program, how to access carved out services, and how obtain referrals to appropriate community resources and other agencies.

C. Contractor must ensure its Member services staff are educated on assisting Members with disabilities, chronic conditions, and components of Health Equity in accordance with Exhibit A, Attachment III, Subsection 5.2.11.C. *(Cultural and Linguistic Programs and Committees)*. This includes assisting Members with access barriers, disability access issues, referral to appropriate clinical services, Grievance and Appeal resolution, and State Hearings.

D. Contractor's Member services staff must refer Potential Members to the DHCS Enrollment broker when Potential Members request Enrollment with Contractor.

E. Contractor's Member services staff must refer Potential Members to their local county office for Medi-Cal eligibility determinations or redeterminations.

F. Contractor must ensure its Member services staff assist Members with a warm hand-off to Subcontractors and Downstream Subcontractors when Member services functions are delegated under a Subcontractor Agreement or Downstream Subcontractor Agreement.

5.1.3 Member Information

A. Contractor must provide all new Members, and Potential Members upon request, with information in compliance with 42 CFR section 438.10,

Welfare and Institutions Code (W&I) section 14406, 22 CCR section 53895, and as set forth in this provision.

B. Contractor must provide information as required in 42 CFR section 438.10, W&I section 14406, and 22 CCR section 53895 no later than seven calendar days after the effective date of a Member's Enrollment.

C. Contractor must distribute the information required by Exhibit A, Attachment III, Subsection 5.1.3 *(Member Information)*, Paragraphs A-B annually, and upon a Member's request. Contractor must ensure the information is current and has prior approval for distribution from DHCS.

D. All Member Information must be in a format that is easily understood and in a font size no smaller than 12-point, in compliance with all requirements in 42 CFR sections 438.10, 438.404, and 438.408, W&I section 14029.91, and 22 CCR section 53876. Member Information is defined in this Contract and discussed in detail in APL 25-005. Member Information includes, but is not limited to, the Member Handbook (also called the Evidence of Coverage, or EOC), Provider Directory, and all mailings and notices critical to obtaining services, including form letters, Notices of Action (NOAs), NABDs, Grievances or Appeals, welcome packets, Marketing information, preventive health reminders, Member surveys, notices advising of the availability of free language assistance, and newsletters.

E. If a Member or Potential Member requests Member Information in a format other than as printed materials, Contractor must provide the Member Information in the alternate formats, including Braille, large-size print font no smaller than 20-point, accessible electronic format, or audio format.

F. Contractor must ensure that all Member Information is provided to Members at a sixth grade reading level and approved by DHCS before distribution. Member Information must inform Members on Contractor's processes and the Member's right to make informed health decisions.

1) Contractor must submit to DHCS for review and approval their policy and process for collecting requests and disseminating materials in an alternative format when requested by Member.

2) For Members with disabilities, including visual impairment Contractor must provide Member Information in all Threshold Languages, alternative formats as specified by DHCS and in APL 25-005 and APL 25-016 (including Braille, large-size print font no smaller than 20-point, accessible electronic format, audio compact disc (CD) format, or data CD format), and through Auxiliary Aids at no cost and upon request. Contractor must provide Member

Information in a timely fashion appropriate for the format being requested and taking into consideration the special needs of Members with disabilities or Limited English Proficiency (LEP) Members.

a) Contractor must inform Members who exhibit or mention difficulty reading print communications of their right to receive Auxiliary Aids and services, including alternative formats.

b) For Members who request an electronic alternative format to receive Member information, Contractor must inform the Member that, unless they request a password-protected format, the Member Information will be provided in an electronic format that is not password protected, which may make the information more vulnerable to loss or misuse. Contractor must clearly communicate to Members that they may request an encrypted electronic format with unencrypted instructions on how the Member can access the encrypted information.

c) Contractor must accommodate the communication needs of qualified individuals with disabilities, which may include communication with the Member's Authorized Representative (AR) or someone with whom it is appropriate for Contractor to communicate, such as a Member's disabled spouse. For these qualified individuals, Contractor must facilitate alternative format requests as identified in this Paragraph, as well as requests for other Auxiliary Aids and services.

3) Contractor must establish policies and procedures to ensure Members receive all Member Information in a Threshold Language or alternative format of their choice as required by 42 CFR section 438.10, W&I section 14029.91, and Exhibit A, Attachment III, Subsection 5.2.10.B (*Access Rights*).

4) Contractor must post a DHCS-approved nondiscrimination notice. Contractor must also post a notice with language taglines in a conspicuously visible font size in English, at least the top 15 non-English languages in the State, and any other languages, as determined by DHCS, explaining the availability of free language assistance services, including written translation and oral interpretation, and information on how to request Auxiliary Aids and services, including materials in alternative formats. The nondiscrimination notice and the notice with taglines must include

Contractor's toll-free and Telephone Typewriters (TTY)/Telecommunication Devices for the Deaf (TDD) telephone number for obtaining these services, and must be posted as follows:

a) In a conspicuous place in all physical locations where Contractor interacts with the public;

b) In a location on Contractor's website that is accessible on Contractor's home page, and in a manner that allows Members, Potential Members, and members of the public to easily locate the information; and

c) In the Member Handbook/EOC, and in all Member Information, informational notices, and materials critical to obtaining services targeted to Members, Potential Members, applicants, and the public at large, in accordance with APL 25-005, APL 25-016, 42 CFR section 438.10(d)(2)-(3), and W&I section 14029.91(a)(3) and (f).

5) Contractor's nondiscrimination notice must include all information required by W&I section 14029.91(e), any additional information required by DHCS, and must provide information on how to file a Discrimination Grievance with:

a) Both Contractor and the DHCS Office of Civil Rights, if there is a concern of discrimination based on sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, health status, marital status, gender, gender identity, or sexual orientation, or identification with any other persons or groups defined in Penal Code section 422.56; and

b) The United States Department of Health and Human Services (U.S. DHHS) Office for Civil Rights if there is a concern of discrimination based on race, color, national origin, sex, age, or disability, per W&I section 14029.91(e)(5).

G. Member Information Noticing in Electronic Format

1) Contractor has the option to send Members a notice in Member welcome packets or annual informational mailings to inform Members of how to obtain their Provider Directory and Member Handbook electronically or in a paper version if preferred. The

notice can be an insert, flyer, or other form of noticeable communication.

a) Contractor may provide Seniors and Persons with Disabilities (SPDs) a notice in lieu of a paper Member Handbook in Member welcome packets. Contractor must still provide all SPDs with the paper form of the Provider Directory. The paper form of the Provider Directory may be a personalized, shorter version of the full-sized Provider Directory.

b) Contractor may provide their non-SPD, dual eligible Members a notice on how to access the Provider Directory and Member Handbook electronically in lieu of a paper version in Member welcome packets.

c) Contractor may provide all Members, except SPDs, a notice in lieu of a paper Provider Directory and Member Handbook for annual informational mailings.

2) Prior to using a notice, Contractor must submit the following to DHCS for approval:

a) A written proposal on Contractor's letterhead addressed to "DHCS Contract Manager" requesting to use a notice instead of mailing the informing materials. The proposal must include the following:

i. An overview of Contractor's process for utilizing the notice and how Contractor will meet all notice requirements.

ii. An explanation of the notice's purpose, including a description of the Member population(s) who will receive the notice.

iii. Time frame for implementation.

iv. A statement that Contractor is complying with all applicable State and federal laws, the requirements of this Contract, and other DHCS guidance, including APLs and Policy Letters (PLs).

v. For Member packages only, a proposal of how Contractor will move toward creating a personalized Provider Directory, with a timeline included that

covers the cycle of production to delivery of personalized Provider Directories.

vi. Any other pertinent information necessary for DHCS to review.

b) A written policy and procedure describing in detail the process Contractor will utilize for the notice and how Contractor will continue to meet all language and format requirements set forth in 42 CFR section 438.10(d)(3), Provider Directory and website requirements in accordance with 42 CFR section 438.10(h), and sub-contractual relationship and delegation requirements set forth in 42 CFR section 438.230.

c) A sample of Contractor's proposed notice regarding electronic communications. The notice must be easily identifiable by the Member, state the purpose of each piece of Member material offered, and identify the options Members will have for receiving their Member materials.

3) The notice must be compliant with all the requirements of this Contract and DHCS policy, and federal and State statutes and regulations on Member Information, including 42 CFR sections 438.10 and 438.404, and W&I section 14029.91. DHCS will approve Contractor's notices on a case-by-case basis.

4) DHCS reserves the right to require Contractor to revert to sending printed copies of the Provider Directory and Member Handbook to its Members, at any time.

H. Provider Directory

1) Contractor must submit its complete Provider Directory to DHCS for review and approval prior to initial operations.

2) Contractor must make its Provider Directory available to all Members and to DHCS for distribution as required.

3) Contractor's Provider Directory must be available in both paper and electronic formats. Provider Directory information must be included with Contractor's written Member Information for new Members, and thereafter available upon request. An electronic Provider Directory must be posted on Contractor's website in a machine readable and accessible file and format.

4) Contractor must update and submit its paper and electronic Provider Directories to DHCS in accordance with 42 CFR section 438.10(h)(3)(i)(A)-(B). Contractor must submit under the following timelines:

   a) A paper Provider Directory must be updated at least monthly, if Contractor does not have a mobile-enabled, electronic Provider Directory; or quarterly, if Contractor has a mobile-enabled, electronic Provider Directory; and

   b) An electronic Provider Directory must be updated no later than one week after Contractor receives updated provider information.

5) Contractor's Provider Directory submission must include complete, accurate and updated Provider Directory and Network information and data and submit as required by 42 CFR section 438.10(h)(3). Contractor's Provider Directory must also comply with all requirements in PL 11-009. DHCS is authorized to require changes or corrections to Contractor's Provider Directory at any time.

6) Contractor must implement and maintain a publicly accessible standards-based Provider Directory API, as described in 42 CFR section 431.70 and APL 22-026, which must include the information required here in Exhibit A, Attachment III, Subsection 5.1.3.H (*Member Information*). The Provider Directory API must meet the technical standards in 45 CFR section 170.215, excluding the security protocols related to user authentication and authorization.

7) Provider Directories must comply with 42 CFR section 438.10(h) and H&S section 1367.27, and must include the following information for in-Network PCP, Specialists, hospitals, Enhanced Care Management (ECM), Community Support Providers, Behavioral Health Providers, and any other Providers (e.g., Community Health Workers (CHW)) contracted for Medi-Cal Covered Services:

   a) The Provider's or site's location name and any group affiliation(s), National Provider Identifier (NPI) number, street address(es), all telephone numbers associated with the practice site, and, if applicable, website URL for each Service Location;

   b) Provider's specialty type and paneling status that allows them to treat specific populations, including but not limited

to, whether they are a California Children's Services (CCS) paneled provider;

c) Whether the Provider is accepting new patients;

d) Information on the Provider's affiliated medical group or Independent Physician/Provider Associations (IPA), NPI number, address, telephone number, and, if applicable, website URL for each Physician Provider of affiliated group or IPA;

e) The hours and days when each Service Location is open, including the availability of evening or weekend hours;

f) The services and benefits available, including accessibility symbols approved by DHCS confirming whether the office/facility (exam room(s), equipment, etc.) can accommodate Members with physical disabilities as required by PL 11-009;

g) The Provider's cultural and linguistic capabilities, including whether non-English languages and American Sign Language are offered either by the Provider or a skilled medical interpreter at the Provider's facility;

h) Contractor must ensure their Provider Directory includes up-to-date information identifying which Network Providers have voluntarily affirmed they offer and have provided gender-affirming services, as described in APL 24-017.

   i) Contractor must ensure their Network Provider Directories are updated within 30 days following an investigation and finding that information regarding which Providers offer and have provided gender-affirming services is inaccurate or misleading.

i) The telephone number to call after normal business hours;

j) Identification of Network Providers or sites that are not available to all or new Members;

k) The link to the Medi-Cal Rx Pharmacy Locator, which can be found on the dedicated Medi-Cal Rx website described in APL 25-013.

I. Member Handbook

Contractor must comply with the requirements in 22 CCR section 53895(b) by distributing a Member Handbook, also known as an Evidence of Coverage and Disclosure Form (EOC/DF) to each Member and to Potential Members, upon request. The Member Handbook must meet all requirements in 42 CFR section 438.10(g), 22 CCR section 53881, and any other requirements in State and federal law, and this Contract. In addition, the Member Handbook must meet all applicable requirements contained in 42 CFR section 438.10(d), W&I section 14029.91, 22 CCR section 53876 for Limited English Proficiency (LEP) Members and Potential Members and H&S section 1363 as to translation, print size, readability, and understandability of text.

1) Contractor must provide to each Member, or Member's family unit, a Member Handbook that constitutes a full and fair disclosure of the Member's right to obtain and Contractor's provision of all Medi-Cal services that are available and accessible to the Member. Contractor must post its most recent Member Handbook to its website.

2) Contractor must use the DHCS template for its Member Handbook. Contractor must submit its information that is specific to Contractor, where applicable. Contractor must submit its completed Member Handbook, with all Contractor-specific information included in redline, for review and approval by DHCS before distribution to Members.

3) Contractor must make the revised Member Handbook available to Members based on the timeframes required by State and federal law and at any time DHCS, a Member, or a Potential Member requests a copy.

4) Although Contractor is required to use the DHCS Member Handbook template, Contractor remains solely responsible for ensuring that Members receive the following information through the Member Handbook:

   a) Contractor's name, address, toll-free telephone number(s) for Member services, Medi-Cal Rx telephone number(s) and website information, any other Contractor staff providing services directly to Members, and information on Contractor's Service Area;

   b) Information on how to access services in the Medi-Cal managed care system, including a description of the full

amount, duration, and scope of Covered Services and how to obtain services under this Contract. The Member Information must also include information on services that require Prior Authorization and how to request it, health education and how to access appropriate community resources and other agencies, interpretive services provided by Contractor's staff and at service sites, and an explanation of "carved- out" services, including Specialty Mental Health Services, and any service limitations and exclusions from coverage or charges for services. The Member Handbook must also include information on services to which Contractor, Subcontractor, Downstream Subcontractor, or a Network Provider may have a moral objection to perform or support and alternative methods for obtaining those services;

c) Procedures for accessing Covered Services, which explain that Covered Services will be obtained through Contractor's Network Providers unless otherwise allowed under this Contract;

d) A description of the Member identification card issued by Contractor, if applicable, and an explanation of its use in authorizing or assisting Members in obtaining services;

e) Procedures for selecting or requesting a change in PCP at any time, any requirements for a Member to change their PCP, reasons for which a request for a specific PCP may be denied, and reasons why a PCP may request a change;

f) The purpose and value of scheduling and completing an Initial Health Appointment (IHA);

g) The availability and procedures for obtaining after-hours services 24 hours a day, seven days a week, including the appropriate Network Provider locations and telephone numbers to obtain services. This must include an explanation of the Members' right to interpretive services, at no cost, to assist in receiving after-hours services;

h) Definition of what constitutes an Emergency Medical Condition, Emergency Services, and post-stabilization services. The Member Handbook must expressly state that Prior Authorization is not required to receive Emergency Services and include the use of 9-1-1 for obtaining Emergency Services;

i) The right to receive Emergency Services in any hospital or other setting, and procedures for obtaining Emergency Services from specified Network Providers or from out-of-Network Providers, including Emergency Services outside of Contractor's Service Area. This includes the right to the provision of at least a 72-hour supply of Medically Necessary medication in an emergency situation is provided;

j) Process for referral to Specialists, including an explanation of the Prior Authorization process, in sufficient detail so the Member can understand how the process works, including authorization and referral timeframes and alternative access standards as required by W&I section 14197.04, APL 23-001, and APL 21-011;

k) Procedures for obtaining Emergency Medical Transportation (EMT) and Non-Emergency transportation services to service sites that are offered by Contractor or available through the Medi-Cal program, and how to obtain such services. Include a description of medical transportation, including EMT, Non-Medical Transportation (NMT) and Non-Emergency Medical Transportation (NEMT) services, and how Contractor coordinates access to appropriate transportation, when needed;

l) The right to file a Grievance and request an Appeal with Contractor, and procedures for filing either orally, in writing, or over the phone. Contractor must inform Members of all Appeal and State Hearing rights when it makes a decision to deny, delay or modify a Member's request for services as set forth in Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*);

m) Information on disenrollment from Contractor. Contractor must ensure that the following information is included:

   i. The causes for which a Member may lose eligibility to receive services under this Contract as set forth in Exhibit A, Attachment III, Subsection 4.2.2 (*Disenrollment*), and the procedures for disenrollment due to the loss of eligibility.

   ii. An explanation of the expedited disenrollment process for Members qualifying under conditions specified under 22 CCR section 53889(j), which

includes Children receiving services under the Foster Care or Adoption Assistance Programs, Members who require out-of-Network transplant services if they are unavailable in-Network, and Members already enrolled in another Medi-Cal, Medicare, or commercial managed care plan.

n) An explanation of the Member's right to disenroll at any time, and reenroll in the competing Medi-Cal managed care plan in the county (in counties where another Medi-Cal managed care plan is available), subject to the requirements in 22 CCR 53889, 22 CCR 53891(c) and any restricted disenrollment period;

o) Information on the Member's right to a Medi-Cal State Hearing, the process for obtaining a State Hearing, the timeframe to request a State Hearing, and the rules that govern representation in a State Hearing. Contractor must ensure the following information is included:

i. The circumstances under which an expedited State Hearing is possible;

ii. Information stating that Contractor will assist in completing the State Hearing request when a health care service requested by the Member or Provider has been denied, delayed, or modified, as required by APL 21-011;

iii. The timelines which govern a Member’s right to a State Hearing, pursuant to W&I section 10951 and for an expedited State Hearing pursuant to W&I section 10951.5;

iv. The California Department of Social Services (DSS) Public Inquiry and Response Unit toll-free telephone number (1-800-952-5253) to request a State Hearing; and

v. Contractor’s obligation to continue the disputed service(s) until there is a final decision on the State Hearing as long as if the Member requests a State Hearing in the specified timeframe(s) as required by 42 CFR section 438.420.

p) The availability of, and procedures for obtaining services at FQHCs, RHCs and IHCPs;

q) The Member's right to seek family planning services from any qualified family planning Provider in the Medi-Cal program, including out-of-Network Providers; how to access these services; that a referral is not necessary; and a description of the limitations on the services that Members may seek out-of-Network. The DHCS Office of Family Planning toll-free telephone number (1-800-942-1054) that provides consultation and referral to family planning clinics must also be included. Contractor must ensure that the following statement, or similar language provided by DHCS is included:

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

r) Procedures for providing female Members with direct access to an in-Network women's health Specialist for women's preventive and routine health care services without requiring Prior Authorization. Access to a women's health Specialist must be provided in addition to the Member's designated PCP if the PCP is not a women's health Specialist;

s) Information on the availability of and procedures for obtaining Certified Nurse Midwife (CNM) and Nurse Practitioner services, pursuant to Exhibit A, Attachment III, Subsection 5.2.8.G. (*Specific Requirements for Access to Programs and Covered Services*);

t) Information on how to access the DHCS Medi-Cal Managed Care Ombudsman Program and toll-free telephone number (1-888-452-8609), and the DMHC HMO Consumer Service toll-free telephone number (1-800-400-0815) for resolution of Member concerns and complaints;

u) Information on the provision and availability of services covered under the California Children's Services (CCS) Program from out-of-Network Providers, and how to access CCS Program;

v) Information on how to obtain Minor Consent Services through Contractor's Network, an explanation of those services, and information on how Minor Consent Services can also be obtained from out-of-Network Providers without requiring Prior Authorization;

w) Information on the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit for Members less than 21 years of age, and that it includes all Medically Necessary health care, diagnostic services, treatments, and other measures listed in 42 United States Code (USC) section 1396d(a) and (r), whether or not covered under the California Medicaid State Plan. All EPSDT services are Covered Services unless expressly excluded under this Contract;

x) An explanation on how to use the Medi-Cal Fee-For-Service (FFS) system when Medi-Cal services are excluded or limited under this Contract, and how to obtain additional information;

y) An explanation that an American Indian Member's status as a Member is voluntary and that an American Indian Member cannot be required to enroll in a Medi-Cal managed care plan and has the right to access IHCP, choose an IHCP within Contractor's Network as a PCP, and disenroll from Contractor at any time, without cause;

z) Language regarding the positive benefits of organ donations and how a Member can become an organ or tissue donor, pursuant to H&S section 7158.2. This information must be provided in the Member Handbook as well as Contractor's newsletter and any other direct communication with Members, and must be provided the Members annually under H&S section 7158.2;

aa) Confirmation of whether Contractor offers financial bonuses or other incentives to its Network Providers. This information must inform the Member of the right to request additional information about these bonuses or incentives from

Contractor, their Network Provider, or the Network Provider's medical group or IPA, pursuant to H&S section 1367.10;

bb) Instructions on how a Member can request a copy of, or the website link to locate, Contractor's non-proprietary clinical and administrative policies and procedures;

cc) That oral interpreter services are available for any language spoken by the Member, and that the Member can inform Contractor of their preferred language to receive written translations of Member materials in the identified Threshold Languages, both free of charge, with instruction on Contractor's obligations to ensure these services are provided;

dd) That Auxiliary Aids and services are available upon request and at no cost for Members with disabilities, and how to access these services;

ee) Information on how to report suspected Fraud, Waste and Abuse; and

ff) Information on how to request Community Supports.

J. Member Identification Card

Contractor must provide an identification card to each Member, which identifies the Member and authorizes them to access Covered Services. The card must inform the Member that they may seek Emergency Services from out-of-Network Providers. The card must inform the Member of the Medi-Cal Rx telephone number. The Member identification card must also inform the Member that Emergency Services are covered by Contractor without Prior Authorization, and at no cost to the Member.

5.1.4 Primary Care Provider Selection

A. Contractor must implement and maintain DHCS-approved procedures to ensure that each new Member who is not enrolled in comprehensive Other Health Coverage (OHC) has an appropriate and available PCP. Comprehensive OHC refers to:

1) Members with the OHC Code indicator C, H, F, K, or P as listed in the 834 file, or,

2) OHC with a scope of coverage of at least Outpatient, Inpatient, and Medical/Allied (OIM) Services found in positions 119 through 126 in the Health Insurance System Database (HISDB) file.

B. Contractor must provide each new Member an opportunity to select a PCP within the first 30 calendar days of Enrollment. Contractor must make best efforts to ensure the Member is assigned to the PCP the Member selected at the time of their Enrollment, unless the PCP is unavailable or is not accepting new patients.

C. If the Member does not select a PCP within 30 calendar days of the effective date of Enrollment, Contractor must assign that Member to a PCP and notify the Member and the assigned PCP no later than 40 calendar days after the Member's Enrollment. Contractor must ensure that adverse selection does not occur when Members are assigned to PCPs.

1) Contractor must allow Members to select a clinic that provides Primary Care in lieu of selecting a specific PCP, where available.

2) If Contractor's Network includes Nurse Practitioners (NP), Certified Nurse Midwives (CNMs), OB-GYN, or Physician Assistants, the Member may select one of these practitioners as their PCP within 30 calendar days of Enrollment to provide Primary Care services in accordance with 22 CCR section 53853(a)(4).

3) SPD Members may select a Specialist or clinic as a PCP if the Specialist or clinic agrees to serve as the Member's PCP and is qualified to treat the health conditions of the SPD Member, in accordance with W&I section 14182(b)(11).

4) Contractor must ensure that Members are allowed to change their PCP, NP, CNM, or Physician Assistant assignment, upon request, by selecting a different PCP from Contractor's Network.

D. Contractor must inform Members through direct outreach to provide an explanation for the reason the Member could not be assigned to their selected PCP.

E. Contractor must ensure that Members who have an established relationship with a Network Provider, and who want to continue their patient-Provider relationship, are assigned to that Provider without disruption in the Member's care if the Member's existing relationship meets the requirements set forth in APL 18-008 (revised).

F. Contractor must ensure that Members can choose Traditional and Safety-Net Providers as their PCP, and that American Indian Members may choose an IHCP within Contractor's Network as their PCP.

G. Contractor is not obligated to require full benefit dual eligible Members to select a Medi-Cal PCP. Nothing in this section must be construed to require Contractor to pay for services that would otherwise be paid for by Medicare.

H. If a Member does not select a PCP within 30 calendar days of the effective date of Enrollment, Contractor must use utilization data or other data sources in its possession or provided by DHCS to select a PCP for the Member. This includes review of electronic data to confirm existing Provider relationships for the purpose of PCP assignment, including a Specialist or clinic for an SPD if they have indicated they have a preference for either to act as their PCP. Contractor must comply with all federal and State privacy laws in the provision and use of this data.

I. Contractor must notify the PCP that a Member has selected or been assigned to the Provider within ten calendar days from the date selection or assignment is complete.

J. Contractor must maintain procedures that proportionately include contracting with Traditional and Safety-Net Providers in the assignment process for Members who do not choose a PCP. Contractors in public hospital health system counties must assign PCPs in compliance with W&I section 14199.1.

5.1.5 Notices of Action for Denial, Deferral, or Modification of Prior Authorization Requests

Contractor must notify Members of a decision to deny, defer, or modify requests for Prior Authorization, in accordance with 42 CFR section 438.210(c) and 22 CCR sections 51014.1 and 53894 by providing a NOA to Members and/or their AR, regarding any denial, deferral, or modification of a request for approval to provide a health care service. This notification must be provided in accordance with all requirements set forth in Exhibit A, Attachment III, Subsection 4.6.4 (*Notice of Action*).

Exhibit A, ATTACHMENT III

5.2 Network and Access to Care

5.2.1 Access to Network Providers and Covered Services
5.2.2 Network Capacity
5.2.3 Network Composition
5.2.4 Network Ratios
5.2.5 Network Adequacy Standards
5.2.6 Access to Emergency Service Providers and Emergency Services
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5.2.8 Specific Requirements for Access to Programs and Covered Services
5.2.9 Network and Access Changes to Covered Services
5.2.10 Access Rights
5.2.11 Cultural and Linguistic Programs and Committees
5.2.12 Continuity of Care for Seniors and Persons with Disabilities
5.2.13 Network Reports
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5.2.15 Street Medicine

5.2 Network and Access to Care

5.2.1 Access to Network Providers and Covered Services

A. Primary Care

1) Contractor must ensure that each Member has an assigned Primary Care Provider (PCP) who is available and physically present at the Service Location for sufficient time to ensure access and appointments for the assigned Member when medically required. This requirement does not preclude an appropriately licensed Provider from being a substitute for the Member's assigned PCP in the event of vacation, illness, or other unforeseen circumstances.

2) Contractor must have processes in place to assist Members in selecting PCPs who are accepting new patients.

3) Contractor must consider the requirements in Welfare and Institutions Code (W&I) section 14182(b)(11) when assigning Members who are Seniors and Persons with Disabilities (SPD) to a PCP. Additionally, Contractor must ensure that Members have the option of selecting an Indian Health Care Provider (IHCP), Federally Qualified Health Center (FQHC), or Rural Health Clinic (RHC), as their PCP, where available.

B. Specialists

1) Contractor must ensure that Members have access to Specialists for Medically Necessary Covered Services in accordance with W&I section 14197, 22 CCR section 53853, and 28 CCR section 1300.67.2.2.

2) Contractor must maintain an adequate Network that includes adult and pediatric Specialists, and at a minimum, the core Specialists required in W&I section 14197(h)(2), within its Network to ensure Medically Necessary specialty care is available in accordance with 22 CCR section 53853(a), and W&I sections 14182(c)(2) and 14197.

C. Contractor must ensure its Network Providers, Subcontractors, and Downstream Subcontractors have adequate Networks and staff within its Service Area, including Physicians, nurses, and administrative and other support staff to ensure that they have sufficient capacity to provide and coordinate care for Covered Services are provided in accordance with

W&I section 14197, 22 CCR section 53853, 28 CCR section 1300.67.2.2, and all requirements in this contract.

D. Contractor must monitor Subcontractors and Downstream Subcontractors to ensure they can adequately deliver culturally and linguistically competent care including offering interpreter services when a Limited English Proficient (LEP) Member accesses a Provider who does not speak the Member's language.

E. Contractor must ensure that Members have access to all Non-Specialty Mental Health and Substance Use Disorder (SUD) Covered Services in accordance with 42 Code of Federal Regulations (CFR) section 438.900 *et seq.* Contractor must coordinate care for all Specialty Mental Health Services (SMHS) and SUD services and provide referrals including mechanisms to track completion of follow up visits, to the county mental health plan (MHP) and Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS) services as outlined in Exhibit A, Attachment III, Section 5.5 (*Mental Health and Substance Use Disorder Benefits*)

5.2.2 Network Capacity

A. Contractor must maintain a Network adequate to provide the full scope of benefits to 60 percent of all Potential Members or current Member Enrollment, whichever is higher, within its Service Area. Contractor must increase the capacity of the Network as necessary to accommodate all Enrollment growth beyond the 60 percent.

B. Contractor may request to renegotiate its Network capacity requirement with DHCS if utilization by Contractor’s Members does not exceed 75 percent of the required Network capacity, after the first 12 months of operation. Any such change is subject to DHCS review and approval.

5.2.3 Network Composition

A. Contractor must maintain an adequate Network within its Service Area, in compliance with W&I section 14197, and if necessary to ensure contract compliance with Network adequacy. Contractor may offer to contract with Providers in adjoining Service Areas but must make good faith efforts to contract with Providers within Contractor’s Service Area. Contractor’s Network must include at a minimum adult and pediatric PCPs, obstetrics, and gynecology (OB/GYNs), adult and pediatric Behavioral Health Providers, adult and pediatric Non-Specialty outpatient Mental Health Service (NSMHS) Providers, adult and pediatric Specialists, hospitals, and Long-Term Care (LTC) Providers to ensure adequate access to all Medically Necessary Covered Services for all Members and to meet all Network adequacy requirements.

B. Contractor must maintain an adequate Network of Allied Health Personnel, supportive paramedical personnel, public hospitals and health care systems, care navigators, caseworkers, and public health nurses, and an adequate number of accessible service sites to ensure adequate access to all Medically Necessary Covered Services for all Members.

C. Contractor must include in its Network, where available, IHCP, FQHC, RHCs, Freestanding Birthing Centers (FBC), Certified Nurse Midwives (CNMs), and Licensed Midwives (LM) in accordance with W&I section 14087.325, Medicaid State Health Official Letter #16-006, All Plan Letter (APL) 18-022, and APL 23-001.

1) If Contractor is a local initiative health plan model, it must offer to contract with all FQHCs and RHCs in its county(ies), in accordance with W&I section 14087.325. Local initiative health plans must maintain and provide supporting documentation of all contracting efforts with each FQHC and RHC in its county(ies) to DHCS upon request, even if Contractor has a minimum of one active contract with an FQHC and RHC in their county(ies).

2) If Contractor is not a local initiative health plan model, it must contract with a sufficient number of and include at least one FQHC, one RHC, and one FBC in the Network, where available in Contractor's Service Area(s), to the extent that the FQHC, RHC, and FBC Providers are licensed and recognized under State law.

D. Contractor must offer to contract with all IHCP available in each county(ies) in which Contractor operates in accordance with 22 CCR section 55120. If Contractor is unable to contract with an IHCP, Contractor must allow eligible Members to obtain services from out-of-Network IHCP in accordance with 42 CFR section 438.14.

E. Contractor must make good faith efforts to contract with at least one cancer center within their Networks and subcontracted Networks, if applicable, within each county in which Contractor operates for the provision of Covered Services to any eligible Member diagnosed with complex cancer diagnosis in accordance with W&I section 14197.45.

F. Contractor must continually ensure that the composition of its Network meets the ethnic, cultural, and linguistic needs of Contractor's Members.

G. Contractor must have an adequate number of NSMHS Providers to provide Medically Necessary, NSMHS based on current and anticipated utilization trends for its Members.

H. Contractor must include in its Network any traditional and Safety-Net Provider that is willing to contract under the same terms and conditions that Contractor offers to any other similar Provider in accordance with 22 CCR section 53800(b)(2)(C)(1).

I. Contractor must ensure that every LTC Provider in its Service Area that is licensed by the California Department of Public Health (CDPH) as a qualified LTC Provider is included in Contractor's Network, to the extent that the LTC Provider remains licensed, certified, operating, and is willing to enter into a Network Provider Agreement with Contractor on mutually agreeable terms and meets Contractor's Credentialing and quality standards. If Contractor determines that additional LTC Providers are necessary to meet the needs of its Members, Contractor must offer to contract or enter into a letter of agreement with any additional CDPH licensed LTC Providers in its Service Area or in adjoining Service Areas.

J. Contractor must receive a preapproval or assessment of suitability from CDPH prior to the execution of a Network Provider Agreement for LTC Providers undergoing a change of ownership. Network Provider Agreements must have a clause that LTC Providers must notify Contractor if it is undergoing a change of ownership so Contractor can obtain preapproval or assessment of suitability from CDPH.

K. Contractor must ensure that every CBAS Provider within Contractor's Service Area, that has been approved by the California Department of Aging (CDA) as a CBAS Provider, is included in Contractor's Network to the extent that the CBAS Provider remains licensed as an Adult Day Health Care (ADHC) Center, is certified and enrolled as a Medi-Cal Provider, is willing to enter into a Network Provider Agreement with Contractor on mutually agreeable terms, and meets Contractor's credentialing and quality standards. Contractor must contract with a sufficient number of Community-Based Adult Service (CBAS) Providers to timely meet the needs of Members who are CBAS-eligible. Contractor must have an adequate number of CBAS Providers that are geographically located within one hour's transportation time of its CBAS-eligible Members and that are appropriate for and proficient in addressing CBAS-eligible Members' specialized health needs and acuity, communication, cultural, and language needs and preferences. Contractor must also meet expected CBAS-utilization without a waitlist.

5.2.4 Network Ratios

A. Contractor must continually comply with 22 CCR sections 53853(a)(1) - (2) and ensure that its Network meets the following full-time equivalent (FTE) Physician to Member ratios:

1) FTE Primary Care Providers that are Physicians: Member 1:2,000

2) FTE Total Physicians: Member 1:1,200

B. Contractor must ensure that FTE non-physician medical practitioner's Member caseload does not exceed 1,000 patients in accordance with 22 CCR section 53853(a)(3).

C. Contractor must ensure compliance with 22 CCR sections 51240 and 51241, and Business and Professions Code sections 3516 and 2836.1. Contractor must ensure full-time equivalent Physician supervisor to non-physician medical practitioner ratios do not exceed the following:

1) Physician Supervisor: Nurse Practitioners 1:4

2) Physician Supervisor: Physician Assistants 1:4

3) A Physician supervisor may not supervise more than four non-physician medical practitioners in any combination.

5.2.5 Network Adequacy Standards

A. Timely Access

1) Contractor must continuously monitor and enforce Network Providers', Subcontractors', and Downstream Subcontractors' compliance with the requirements in W&I section 14197(d)(1)(A), 28 CCR section 1300.67.2.2, Health and Safety Code (H&S) section 1367.03, and the requirements in this Contract.

2) Contractor must develop, implement, and maintain procedures to monitor and ensure that Contractor, Network Providers, Subcontractors, and Downstream Subcontractors:

a) Comply with requirements for Members to obtain appointments for routine care, Urgent Care, routine specialty referral appointments, prenatal care, Children's preventive periodic health assessments, and adult Initial Health Appointments (IHAs) in accordance with W&I section 14197, and 28 CCR section 1300.67.2.2:

i. Urgent Care appointment for services that do not require Prior Authorization within 48 hours of a request;

ii. Urgent Care appointment for services that do require Prior Authorization within 96 hours of a request;

iii. Non-urgent appointments for Primary Care within ten (10) business days of request;

iv. Non-urgent appointments with Specialists within 15 business days of request;

v. Non-urgent appointment with a non-physician mental health Provider with ten (10) business days of request;

vi. Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, or illness within 15 business days of request;

vii. Availability of LTC Providers for the following counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara within five (5) business days of request;

viii. Availability of LTC Providers for the following counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura within seven (7) business days of request; and

ix. Availability of LTC Providers for the following counties: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Fresno, Glenn, Humboldt, Imperial, Inyo, Kern, Kings, Lake, Lassen, Madera, Mariposa, Mendocino, Merced, Modoc, Mono, Monterey, Napa, Nevada, Plumas, San Benito, San Bernardino, San Luis Obispo, Santa Barbara, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo, and Yuba within 14 business days of request.

b) Offer Members appointments for Covered Services within a time frame appropriate for their health condition but no

longer than the appointment timeframes set forth in 28 CCR section 1300.67.2.2, unless the Member's preference is to wait for a later appointment from a specific Network Provider. The applicable waiting time for a particular appointment may be extended if the following conditions are met:

i. The Member's Medical Record notes that waiting will not have a detrimental impact on the Member's health, as determined by the referring or treating licensed health care Provider, or by the health professional providing triage or screening services, who is acting within the scope of their practice consistent with professionally recognized standards of practice;

ii. The Provider's decision to extend the applicable waiting time is noted in the Member's Medical Record and made available to DHCS upon request; and

iii. Contractor ensures that the Member receives notice of the Provider's decision to extend the applicable waiting time with an explanation of the Member's right to file a Grievance disputing the extension.

c) Contractor must provide the appointment time standards to Network Providers, Subcontractors, and Downstream Subcontractors, and monitor appointment waiting times in Network Providers' offices pursuant to 42 CFR section 438.206, W&I section 14197, and 28 CCR section 1300.67.2.2. Contractor must also ensure that Network Providers comply with requirements for follow up on missed appointments;

d) Offer hours of operation to Members that are no less than the hours of operation offered to non-Medi Cal patients, or to Medi-Cal Fee-For-Service (FFS) beneficiaries if the Network Provider serves only Medi-Cal beneficiaries; and

e) Maintain procedures for triaging Members' telephone calls, providing telephone medical advice, and accessing telephone interpreters 24 hours a day, seven days a week.

3) During normal business hours, the waiting time for a Member to speak by telephone with Contractor's customer service representative must not exceed ten minutes.

4) Contractor must ensure its customer service representatives have knowledge and competency to assist in resolving Members' questions and concerns.

5) Contractor must have a medical director or licensed Physician acting on behalf of Contractor's medical director, who is available 24 hours a day, seven days a week to assist with access issues.

6) Contractor must ensure that its Network Providers, Subcontractors, and Downstream Subcontractors participate in all timely access survey(s) and Network adequacy activities conducted by DHCS or its contractors. Contractor entering into new or amended Network Provider or Subcontractor agreements with Network Providers, Subcontractors, and/or Downstream Subcontractors must include language requiring Provider participation.

B. Time or Distance

1) Contractor must ensure that its Network Providers, Subcontractors, and Downstream Subcontractors meet the time or distance standards for adult and pediatric PCPs, adult and pediatric core Specialists, OB/GYN primary and specialty care, adult and pediatric mental outpatient health Providers, and hospitals, as required by W&I section 14197(b) and (c).

2) Contractor must either exhaust all other reasonable options for contracting with Providers, including offering to contract with Providers in adjoining Service Areas, or provide evidence to DHCS demonstrating that its delivery structure is capable of delivering the appropriate level of care and access as required by W&I section 14197 prior to submitting an Alternate Access Standard (AAS) request to DHCS.

3) If Contractor is unable to comply with the time or distance standards set forth in W&I section 14197, Contractor must submit an AAS request to DHCS for review and approval in accordance with APL 23-001, detailing how it intends to arrange for Covered Services in accordance with W&I section 14197(e)(3).

4) Contractor must publish on its website its approved AAS requests in accordance with W&I section 14197.04.

5) If Contractor has received an AAS approval from DHCS for a core Specialist, upon a Member's request, Contractor must assist the Member in obtaining an appointment with the appropriate core

Specialist in accordance with W&I section 14197.04. Contractor must either make its best effort to establish a Member-specific case agreement with an out-of-Network Provider or arrange for an appointment with a Network Provider in an adjoining Service Area within the time or distance standards in accordance with W&I section 14197.04. If needed, Contractor must assist in arranging transportation for the Member. Contractor must not be held liable for fulfilling these requirements if either there is no core Specialist within the time or distance standards of this Contract, or the core Specialist has refused to contract in the previous 12 months.

6) Contractors that do not meet time or distance standards without the use of an AAS request must provide documentation demonstrating efforts to engage new Providers to these areas and attempt to contract with them. Contractor must submit this documentation as part of the Network certification report detailed in 5.2.13.

5.2.6 Access to Emergency Service Providers and Emergency Services

A. Contractor must have within its Network, at a minimum, a designated Emergency Services facility, providing care 24 hours a day, seven days a week. This designated Emergency Services facility must have one or more Physicians and one nurse on duty in the facility at all times.

B. Contractor must ensure that Members with Emergency Medical Conditions are seen on an emergency basis and that Emergency Services are available and accessible within Contractor's Service Area seven days a week, 24 hours a day, in accordance with 42 USC sections 1395dd and 1396u-2(b)(2), 42 CFR sections 438.114 and 438.206(c)(1)(iii), and 28 CCR 1300.67(g)(1).

C. Contractor must reimburse the costs of Emergency Services without Prior Authorization pursuant to 42 USC section 1395dd, 42 CFR section 438.114, 28 CCR section 1300.67(g), and 22 CCR section 53216 and 53855.

D. Contractor must have a medical director or licensed physician acting on behalf of Contractor's medical director, who is available 24 hours a day, seven days a week to authorize Medically Necessary Post-Stabilization Care Services, to respond to hospital inquiries within 30 minutes, and to coordinate the transfer of a Member whose Emergency Medical Condition is stabilized.

E. Contractor must ensure that Members have timely access to Medically Necessary follow-up care including but not limited to appropriate referrals to Primary Care, Behavioral Health Services, and social services for

Members who have been screened in the emergency room and do not require Emergency Services.

F. Contractor must coordinate access to Emergency Services in accordance with Contractor's DHCS-approved emergency department protocol, as required in Exhibit A, Attachment III, Section 3.2 (*Provider Relations*).

G. If Contractor delegates its Emergency Services and Post-Stabilization Care Services oversight obligations to Network Providers, Subcontractors, or Downstream Subcontractors, it must ensure a licensed physician is available seven days a week, 24 hours a day, to authorize Medically Necessary Post-Stabilization Care Services and coordinate the transfer of stabilized Members in an emergency department to an appropriate Network Provider, if necessary, as required under Health & Safety Code (H&S) section 1371.4.

5.2.7 Out-of-Network Access

A. Contractor must authorize and arrange for out-of-Network access in the following circumstances:

1) Contractor does not meet Network adequacy requirements set forth in W&I section 14197;

2) Contractor does not have an AAS approved by DHCS and fails to meet the Network adequacy standards set forth in W&I section 14197;

3) Contractor fails to comply with the requirements for timely access to appointments; or

4) Contractor must arrange for access to out-of-Network LTC when Medically Necessary for a Member in cases where Contractor does not have in-Network LTC capacity.

B. Contractor must authorize and arrange for services from out-of-Network Providers when the Provider type is unavailable within the Network but available in an adjoining county(ies). If there is no Network Provider in the adjoining county(ies), Contractor must authorize out-of-Network services to the most appropriate Provider as close to time or distance requirements as possible.

C. Contractor must provide Non-Emergency Medical Transportation (NEMT) or Non-Medical Transportation (NMT) to the out-of-Network Provider, at no cost to the Member. Contractor must inform Members of their right to

obtain NEMT or NMT services to access out-of-Network services in accordance with W&I section 14197.04.

D. Contractor must adequately and timely cover and reimburse Providers for out-of-Network services rendered to its Members for as long as Contractor is unable to provide these services in its Network. Contractor must ensure that the Member is not charged for services furnished out-of-Network. Contractor must also ensure that Members are not balance-billed for any service provided out-of-Network.

5.2.8 Specific Requirements for Access to Programs and Covered Services

A. Family Planning Services

1) Contractor must ensure Members have access to family planning services through any available family planning Provider regardless of whether they are in or out of the Network, without requiring Prior Authorization. Contractor must provide family planning services in a manner that ensures Members have the freedom to choose their preferred method of family planning consistent with 42 CFR section 441.20.

2) Contractor must not restrict a Member's Provider choice for family planning services covered pursuant to 42 CFR section 431.51(a)(3) and W&I section 14132.07.

3) Contractor's Member Handbook must inform Members of their right to access any qualified family planning Provider regardless of whether the Provider is in the Network and without Prior Authorization, in addition to requirements included in Exhibit A, Attachment III, Section 5.1 (*Member Services*).

4) Contractor must ensure that Members are advised of their options for all contraceptive methods to allow them to provide informed consent for their choice of contraceptive method, including sterilization, as required by 22 CCR sections 51305.1 and 51305.3. Members of childbearing age may access the following services from an out-of-Network family planning Provider to temporarily or permanently prevent or delay pregnancy:

a) Health education and counseling necessary to make informed choices and understand contraceptive methods;

b) Limited history and physical examination;

c) Laboratory tests if medically indicated as part of the decision-making process in choice of contraceptive methods, except pap smears if Contractor provides pap smears to meet the United States Preventive Services Taskforce (USPSTF) guidelines, http://www.uspreventiveservicestaskforce.org;

d) Follow-up care for complications associated with contraceptive methods provided or prescribed by the family planning Provider;

e) Provision of contraceptive pills, devices, and supplies;

f) Tubal ligation;

g) Vasectomies; and

h) Pregnancy testing and counseling.

B. Sexually Transmitted Diseases

Contractor must ensure Members have access to Sexually Transmitted Disease (STD) services from any Network Provider or out-of-Network Provider without requiring Prior Authorization or referral. Contractor must allow Members to access out-of-Network STD services through Local Health Department (LHD) clinics, family planning clinics, or through other community STD service Providers.

C. HIV Testing and Counseling

Contractor must ensure that Members have access to confidential Human Immunodeficiency Virus (HIV) counseling and testing services from any Network Provider or out-of-Network Provider without requiring Prior Authorization.

D. Minor Consent Services

Contractor must ensure access to Minor Consent Services for minor Members under the age of 18 from any Network Provider or out-of-Network Provider without requiring Prior Authorization. Contractor must ensure Members are informed of the availability of these services without Prior Authorization. Minors over the age of 12 do not need parent, legal guardian, or Authorized Representative (AR) consent to access these services, if the minor, in the opinion of the attending professional person, is mature enough to participate intelligently in the outpatient services, and Contractor, Network Providers, Subcontractors, or Downstream

Subcontractors are prohibited from disclosing any information relating to Minor Consent Services without the express consent of the minor Member. Minor Consent Services include treatment for the following:

1) Under Age 12

   a) Pregnancy and pregnancy related services

   b) Family planning services

   c) Sexual assault services

2) Age 12 and Older

   a) Pregnancy and pregnancy related services

   b) Family planning services

   c) Sexual assault services

   d) Infectious, contagious, or communicable disease diagnosis and treatment

   e) Sexually transmitted diseases prevention (or infections), diagnosis, and treatment

   f) Drug and alcohol abuse treatment and counseling

   g) Outpatient mental health treatment and counseling. Minors may obtain outpatient mental health services, if in the opinion of the attending professional person determines that the minor is mature enough to participate intelligently in their health care pursuant to Family Code section 6924.

   h) Intimate partner violence services

E. Immunizations

Members may access LHD clinics for immunizations regardless of whether the LHD is in the Network or out-of-Network, without Prior Authorization. Upon request, Contractor must provide updated information on the status of the Member's immunizations to the LHD clinic. Contractor must reimburse LHD clinics that provide immunizations to its Members after receipt of claims and supporting immunization records.

F. Indian Health Care Providers

Contractor must ensure qualified Members have timely access to IHCPs within its Network, where available, as required by 42 USC section 1396j. IHCPs, whether in the Network or out-of-Network, can provide referrals directly to Network Providers without requiring a referral from a Network PCP or Prior Authorization in accordance with 42 CFR section 438.14(b). Contractor must also allow for access to an out-of-Network IHCPs without requiring a referral from a Network PCP or Prior Authorization in accordance with 42 CFR section 438.14(b).

G. Certified Nurse Midwife and Nurse Practitioner Services

1) Contractor must ensure that its Members have access to CNM services as required by 42 United States Code (USC) section 1396d(a)(17) and 22 CCR section 51345.

2) Contractor must ensure its Members have access to Nurse Practitioner (NP) services as required in 22 CCR section 51345.1.

3) Contractor must inform its Members that they have a right to obtain out-of-Network CNM services if CNM services are not available in-Network.

H. Services to Which Network Provider, Subcontractor, or Downstream Subcontractor Has a Moral Objection

1) If a Network Provider, Subcontractor, or Downstream Subcontractor has religious or ethical objections to perform or otherwise support the provision of Covered Services, Contractor must timely arrange for, coordinate, and ensure the Member receives the Covered Services through referrals to a Provider that has no religious or ethical objection to performing the requested service or procedure, at no additional expense to DHCS or the Member.

2) Contractor’s Member Handbook must identify services to which a Network Provider, Subcontractor, or Downstream Subcontractor may have a moral objection and explain that the Member has a right to obtain such services from another Provider. Contractor must also inform the Member that it will assist the Member in locating a Network Provider who will perform the service or procedure.

I. Federally Qualified Health Center, Rural Health Clinic, and Freestanding Birthing Center Services

Contractor must meet federal requirements for access to a FQHC, RHC, and FBC services consistent with 42 USC section 1396b(m) and Medicaid State Health Official Letter #16-006.

J. Community Based Adult Services

Contractor must provide Members with access to CBAS as set forth in the California Advancing and Innovating Medi-Cal (CalAIM) Special Terms and Conditions, or as set forth in any subsequent demonstration amendment or renewal, or successor demonstration, waiver, or other Medicaid authority. Without limitation, Contractor must do the following:

1) Provide and coordinate the provision of unbundled CBAS services for affected CBAS recipients as needed for continuity of care if there is a 5 percent reduction in CBAS Provider capacity in a county within the Service Area relative to the capacity that existed on April 1, 2012; and

2) Arrange Medically Necessary Covered Services for Members with similar clinical conditions as CBAS recipients if there is insufficient CBAS Provider capacity in a county in which ADHC was available prior to April 1, 2012, and coordinate their access to community resources to assist them to remain in the community.

5.2.9 Network and Access Changes to Covered Services

A. DHCS Notification Requirements

1) Contractor must provide notification to DHCS immediately upon discovery of a Network Provider initiated termination or at least 60 calendar days before any change occurs in the availability or location of services Contractor's Covered Services. Contractor must provide this notice if the change impacts more than 2,000 Members or impacts Contractor's ability to meet Network adequacy standards in accordance with APL or other guidance. In the event of an emergency or other unforeseeable circumstance, Contractor must notify DHCS of the change in the availability or location of services as expeditiously as possible.

2) Contractor must provide notification to DHCS immediately, or within 10 calendar days of learning of a Provider's exclusionary status from any database or list included in APL or other guidance.

3) Contractor must notify DHCS when it is unable to contract with a certified CBAS Provider or upon termination of a CBAS Network Provider Agreement. If Contractor and the CBAS Provider cannot

come to an agreement on terms, Contractor must notify DHCS within five Working Days of Contractor's decision to exclude the CBAS Provider from its Network. DHCS may attempt to resolve the contracting issue when appropriate.

4) In accordance with APL or other guidance, Contractor must notify DHCS within 60 calendar days of termination of a LTC Network Provider or immediately if the termination is a result of the LTC Network Provider having been decertified by the California Department of Public Health (CDPH). DHCS will attempt to resolve the contracting issue when appropriate. If termination of a LTC Network Provider Agreement is for a cause related to Quality of Care or patient safety concerns, Contactor may expedite termination of the LTC Network Provider Agreement and transfer Members to an appropriate, contracted LTC Provider in an expeditious manner. DHCS must be notified of the termination within 72 hours of said termination. Contractor must not continue to assign or refer Members to a LTC Network Provider during the 60 calendar days between notifying DHCS and the termination effective date.

B. Member Notification Requirements

1) Contractor must ensure Members are notified in writing of any changes in the availability or location of Covered Services, of any termination of a Network Provider, Subcontractor, or Downstream Subcontractor either 30 calendar days prior to the effective date of the contract termination or at least 15 calendar days after receipt of issuance of the termination notice, whichever is longer, unless directed by DHCS. The notification must be provided to each Member who received Primary Care from, or was seen on a regular basis by, the terminated Provider. This notification must also be submitted to DHCS in writing for approval before its release.

2) Contractor must obtain DHCS approval before sending a notice of termination to its Members no later than 60 calendar days prior to the effective date of the termination. Contractor may use a member notice template previously approved by DHCS. Any changes from the approved template must be submitted to DHCS 60 calendar days prior to the effective date of the termination for review and approval before mailing the notice. In the event of an emergency or other unforeseeable circumstance, Contractor must provide notice of the emergency or other unforeseeable circumstance to DHCS as soon as possible.

5.2.10 Access Rights

A. Equal Access for Linguistic Services

Contractor must ensure equal access to the provision of high quality interpreter and linguistic services for LEP Members and Potential Members, and for Members and Potential Members with disabilities, in compliance with federal and State law, and APL 25-005.

B. Linguistic Services

1) Contractor must comply with W&I section 14029.91 and ensure that all monolingual, non-English-speaking, or LEP Members and Potential Members receive 24-hour interpreter services at all key points of contact, as defined in Paragraph B.4) of this provision, either through interpreters, telephone language services, or other legally compliant electronic options.

2) Contractor must ensure that any lack of interpreter services does not impede or delay a Member's timely access to care.

3) Contractor must comply with Title VI of the Civil Rights Act of 1964 and 42 CFR section 438.10(d) and have the capacity to provide, at minimum, the following linguistic services at no cost to Members or Potential Members:

a) Oral interpreters, sign language Providers, or bilingual Network Providers, Network Provider staff, Subcontractors, and Downstream Subcontractors at all key points of contact. These services must be provided in all languages spoken by Medi-Cal Members and Potential Members and not limited to those that speak the threshold or concentration standards languages.

b) Full and immediate translation of written materials pursuant to 42 CFR sections 438.10(d)(3), 438.404(a), and 438.408(d); W&I section 14029.91; and 22 CCR section 53876 for LEP Members and Potential Members who speak Threshold or Concentration Standard Languages, fully translated Member Information, including: the Member Handbook, Provider Directory, welcome packets, Marketing information, Member rights information, form letters and individual notices, including Notice of Action (NOA) letters, all notices related to Grievances and Appeals including Grievance and Appeal acknowledgement and resolution letters, and any other materials as required by Title VI of the Civil Rights Act of 1964 and APL 25-005;

c) Referrals to culturally and linguistically appropriate community service programs; and

d) Auxiliary Aids such as Telephone Typewriters (TTY)/ Telecommunication Devices for the Deaf (TDD), qualified interpreters including American Sign Language interpreters, and information in alternative formats including Braille, large print text (20 point font or larger), audio, and electronic formats, in accordance with written informing materials in alternative formats, selected by the Member, as specified in APL 25-005 and APL 25-016.

4) Key points of contact include:

a) Medical care settings, such as telephone, advice and Urgent Care transactions, and outpatient Encounters with Providers; and

b) Non-medical care settings, such as Member services, orientations, and appointment scheduling.

C. Access for Persons with Disabilities

Contractor must comply with the requirements of Titles II and III of the Americans with Disabilities Act of 1990 (42 USC sections 12131 et seq. and 12181 et seq.), section 1557 of the Affordable Care Act of 2010 (42 USC section 18116), sections 504 and 508 of the Rehabilitation Act of 1973 (29 USC sections 794 and 794d), Government Code (GC) sections 7405 and 11135, and all applicable implementing regulations, and must ensure access for people with disabilities including, without limitation, accessible web and electronic content, ramps, elevators, accessible restrooms, designated parking spaces, and accessible drinking water.

5.2.11 Cultural and Linguistic Programs and Committees

A. Cultural and Linguistic Program

1) Contractor must develop and implement policies and procedures for assessing the performance of its employees, contracted staff, and other individuals who provide linguistic services, addressing any identified gaps in the provision of cultural and linguistic services by Contractor’s staff, and for overall monitoring and evaluation of its cultural and linguistic services programs.

2) Contractor must have in place and continually monitor, improve, and evaluate cultural and linguistic services that support the delivery of Covered Services to Members. Contractor must ensure it has proper policies and procedures in place to provide appropriate cultural and linguistic services for all of its Members.

3) Contractor must take immediate action to improve the delivery of culturally and linguistically appropriate services when deficiencies are noted.

4) Contractor must be active in recruiting and retaining culturally and linguistically competent Providers that reflect the needs of the Medi-Cal population in Contractor's Service Area.

5) Contractor must have a cultural and linguistic services program, as required by 22 CCR section 53876, that incorporates all requirements of applicable federal and State law, including without limitation those requirements cited in Exhibit A, Attachment III, Subsection 5.2.10 (*Access Rights*), 42 CFR section 438.206(c)(2), 22 CCR sections 51202.5 and 51309.5(a), and 28 CCR sections 1300.67.04(c)(2)(A) - (B) and 1300.67.04(c)(2)(G)(v) - (c)(4). Contractor must ensure immediate translation of all critical Member Information as required by 42 CFR sections 438.10, 438.404(a), and 438.408(d), and W&I section 14029.91.

6) Contractor must review and update its cultural and linguistic services programs to align with the Population Needs Assessment (PNA) implementation and subsequent findings. Contractor must ensure its Network Providers, Subcontractors, Downstream Subcontractors cultural and Health Equity linguistic services programs also align with the PNA.

7) Contractor must implement and maintain a written description of its cultural and linguistic services program which must include, at a minimum, the following:

    a) Its organizational commitment to deliver culturally and linguistically appropriate health care services;

    b) Services that comply with Title VI of the Civil Rights Act of 1964 (42 USC section 2000e et seq.), section 1557 of the Affordable Care Act of 2010 (42 USC section 18116), 42 CFR section 438.10, APL 25-005, and Exhibit A, Attachment III, Subsection 5.2.10 (*Access Rights*).

c) Use of national standards for Culturally and Linguistically Appropriate Services (CLAS) for reference;

d) An organizational chart showing the key staff with overall responsibility for cultural and linguistic services programs;

e) A narrative explaining the organizational chart and describing the oversight and direction to the Community Advisory Committee (CAC), requirements for Contractor's support staff, and reporting relationships. Qualifications of Contractor's staff, including appropriate education, experience, and training must also be included;

f) The role of the PNA to inform Contractor's cultural and linguistic services program priorities in compliance with Exhibit A, Attachment III, Subsection 4.3.2 (*Population Needs Assessment*);

g) The implementation and maintenance of biennial sensitivity, diversity, communication skills, Health Equity, and cultural competency/humility training and related trainings (e.g., providing gender affirming care) for employees and contracted staff (clinical and non-clinical), as determined by Section C of this provision, Diversity, Equity, and Inclusion Training.

h) Contractor's administrative oversight and compliance monitoring of the cultural and linguistic services program and requirements for the delivery of culturally and linguistically appropriate health care services.

B. Linguistic Capability of Employees and Contracted Staff

Contractor must assess and track the linguistic capability of its interpreters or bilingual staff and contracted staff (clinical and non-clinical). Contractor must implement a system to provide adequate training regarding its language assistance programs to all employees and contracted staff who have routine contact with LEP Members or Potential Members and systematically address any identified gaps in Contractor's ability to address Members' cultural and linguistic needs. The training must include instruction on:

1) Contractor's policies and procedures for language assistance;

2) How to work effectively with LEP Members and Potential Members;

3) How to work effectively with interpreters in person and through video, telephone, and other media; and,

4) Understanding the cultural diversity of Members and Potential Members, and sensitivity to cultural differences relevant to delivery of health care interpretation services, in accordance with Exhibit A, Attachment III, Subsection 5.2.11 *(Cultural and Linguistic Programs and Committees).*

C. Diversity, Equity, and Inclusion Training

Contractor must provide biennial sensitivity, diversity, cultural competency/humility and Health Equity training for its employees and contracted staff. Training must consider structural and institutional racism and Health Inequities and their impact on Members, staff, Network Providers, Subcontractors, and Downstream Subcontractors. Contractor must ensure Network Providers and Allied Health Personnel receive pertinent information regarding the PNA findings and the identified targeted strategies. Contractor must use the most appropriate communication method(s) to assure the information can be accessed and understood. The training must include the following requirements:

1) Promote access and delivery of services in a culturally competent manner to all Members and Potential Members, regardless of sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, health status, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code section 422.56; and

2) Information about the Health Inequities and identified cultural groups in Contractor's Service Area which includes but is not limited to: the groups' beliefs about illness and health; need for gender affirming care; methods of interacting with Providers and the health care structure; traditional home remedies that may impact what the Provider recommends to treat the patient; and language and literacy needs.

D. Community Engagement

Contractor must develop a policy and procedure for a Member and family engagement strategy that involves Members and their families as partners in the delivery of Covered Services. This includes, but is not limited to the following:

1) Maintaining an organizational leadership commitment to engaging with Members and their families in the delivery of care;

2) Routinely engaging with Members and families through focus groups, listening sessions, surveys and/or interviews and incorporating results into policies and decision-making, as described in Exhibit A, Attachment III, Subsection 2.2.7.A (*Quality Improvement and Health Equity Annual Plan*);

3) Developing processes and accountability for incorporating Member and family input into policies and decision-making;

4) Developing processes to measures and/or monitor the impact of Member and family input into policies and decision-making;

5) Developing processes to share with Members and families how their input impacts policies and decision-making;

6) Conducting consumer surveys and incorporating results in Quality Improvement (QI) and Health Equity activities as described in Exhibit A, Attachment III, Subsection 2.2.9.C (*Consumer Satisfaction Survey*);

7) Partnering with community based organizations to cultivate Member and family engagement;

8) Maintaining a CAC whose composition reflects Contractor's Member population and whose input is actively utilized in policies and decision-making by Contractor, as outlined below in Exhibit A, Attachment III, Subsection 5.2.11.E. (*Cultural and Linguistic Programs and Committees*).

E. Community Advisory Committee (CAC)

1) Contractor must have a diverse CAC pursuant to 22 CCR section 53876(c), comprised primarily of Contractor's Members, as part of Contractor's implementation and maintenance of Member and community engagement with stakeholders, community advocates, traditional and Safety-Net Providers, and Members.

2) CAC Membership

a) Contractor must convene a CAC selection committee tasked with selecting the members of the CAC. Contractor must demonstrate a good faith effort to ensure that the CAC selection committee is comprised of a representative sample

of each of the persons below to bring different perspectives, ideas, and views to the CAC:

i. Persons who sit on Contractor's Governing Board, which should include representation in the following areas: Safety Net Providers including FQHCs, Behavioral Health Providers, Regional Centers (RC), Local Education Agencies (LEAs), dental Providers, IHCPs, and Home and Community-Based Service (HCBS) program Providers; and

ii. Persons and community-based organizations who are representatives of each county within Contractor's Service Area adjusting for changes in membership diversity.

b) The CAC selection committee must ensure the CAC membership reflects the general Medi-Cal Member population in Contractor's Service Area, including representatives from IHCPs, and adolescents and/or parents and/or caregivers of Children, including foster youth, as appropriate and be modified as the population changes to ensure that Contractor's community is represented and engaged. The CAC selection committee must make good faith efforts to include representatives from diverse and hard-to-reach populations on the CAC, with a specific emphasis on persons who are representative of or serving populations that experience Health Disparities such as individuals with diverse racial and ethnic backgrounds, genders, gender identity, and sexual orientation and physical disabilities.

c) Contractor's CAC selection committee must select all of its CAC members promptly no later than 180 calendar days from the effective date of this contract.

d) Should a CAC member resign, is asked to resign, or is otherwise unable to serve on the CAC, Contractor must make its best effort to promptly replace the vacant seat within 60 calendar days of the CAC vacancy.

e) Contractor must designate a CAC coordinator and maintain a written job description detailing the CAC coordinator's responsibilities, which must include having responsibility for managing the operations of the CAC in compliance with all statutory, rule, and contract requirements, including, but not limited to:

i. Ensuring CAC meetings are scheduled and committee agendas are developed with the input of CAC members;

ii. Maintaining CAC membership, including outreach, recruitment, and onboarding of new members, that is adequate to carry out the duties of the CAC;

iii. Actively facilitating communications and connections between the CAC and Contractor leadership, including ensuring CAC members are informed of Contractor decisions relevant to the work of the CAC;

iv. Ensuring that CAC meetings, including necessary facilities, materials, and other components, are accessible to all participants and that appropriate accommodations are provided to allow all attending the meeting, including, but not limited to, accessibility for individuals with a disability or LEP Members to effectively communicate and participate in CAC meetings;

v. Ensuring compliance with all CAC reporting and public posting requirements; and

vi. The CAC coordinator may be an employee of Contractor, Subcontractor, or Downstream Subcontractor. Contractor's CAC coordinator must not be a member of the CAC or a Member enrolled with Contractor.

3) CAC Meetings

a) Contractor must hold its first regular CAC meeting promptly after all initial CAC members have been selected by the CAC selection committee and at least quarterly thereafter.

b) Contractor must make the regularly scheduled CAC meetings open to the public, posting meeting information publicly on Contractor's website in a centralized location 30 calendar days prior to the meeting, and in no event later than 72 hours prior to the meeting.

c) Contractor must provide a location for CAC meetings and all necessary tools and materials to run meetings, including, but

not limited to, making the meeting accessible to all participants and providing accommodations to allow all individuals to attend and participate in the meetings.

d) CAC must draft written minutes of each of its meetings and the associated discussions. All minutes must be posted on Contractor's website and submitted to DHCS no later than 45 calendar days after each meeting. Contractor must retain the minutes for no less than ten years and provided to DHCS, upon request.

e) Contractor must ensure that CAC members are supported in their roles on the CAC, including but not limited to providing resources to educate CAC members to ensure they are able to effectively participate in CAC meetings, providing transportation to CAC meetings, arranging childcare as necessary, and scheduling meetings at times and in formats to ensure the highest CAC member participation possible.

f) Contractor must demonstrate that CAC input is considered in annual reviews and updates to relevant policies and procedures, including CAC input pursuant to Exhibit A, Attachment III, Subsection 5.2.11.E. (*Cultural and Linguistic Programs and Committees)* that is relevant to policies and procedures affecting quality and Health Equity. Contractor must provide a feedback loop to inform CAC members how their input has been incorporated.

4) Duties of the CAC

The CAC must carry out the duties as set forth in this Contract. Such duties include, but are not limited to:

a) Identifying and advocating for Preventive Care practices to be utilized by Contractor;

b) Contractor must ensure that the CAC is included and involved in developing and updating cultural and linguistic policy and procedure decisions including those related to QI, education, and operational and cultural competency issues affecting groups who speak a primary language other than English. The CAC may also advise on necessary Member or Provider targeted services, programs, and trainings;

c) The CAC must provide and make recommendations to Contractor regarding the cultural appropriateness of communications, partnerships, and services;

d) Contractor must engage their CAC as a part of their participation in LHJs' CHA/CHIP process, as defined further in the PHM Policy Guide;

e) Contractor must provide sufficient resources for the CAC to support the required CAC activities outlined above, including supporting the CAC in engagement strategies such as consumer listening sessions, focus groups, and/or surveys; and

f) The CAC must provide input and advice, including, but not limited to, the following:

i. Culturally appropriate service or program design;

ii. Priorities for health education and outreach program;

iii. Member satisfaction survey results;

iv. Findings of the PNA;

v. Plan Marketing Materials and campaigns.

vi. Communication of needs for Network development and assessment;

vii. Community resources and information;

viii. Population Health Management;

ix. Quality;

x. Health Delivery Systems Reforms to improve health outcomes;

xi. Carved Out Services;

xii. Coordination of Care; and

xiii. Health Equity;

xiv. Accessibility of Services

5) Contractor's Annual CAC Demographic Report

To ensure Contractor's CAC membership is representative of the Communities in Contractor's Service Area, Contractor must complete and submit to DHCS annually an Annual CAC Member Demographic Report by April 1 of each year. The Annual CAC Member Demographic Report must include descriptions of all of the following:

a) The demographic composition of CAC membership;

b) How Contractor defines the demographics and diversity of its Members and Potential Members within Contractor's Service Area;

c) The data sources relied upon by Contractor to validate that its CAC membership aligns with Contractor's Member demographics;

d) Barriers to and challenges in meeting or increasing alignment between CAC's membership with the demographics of the Members within Contractor's Service Area;

e) Ongoing, updated and new efforts and strategies undertaken in CAC membership recruitment to address the barriers and challenges to achieving alignment between CAC membership with the demographics of the Members within Contractor's Service Area; and

f) A description of the CAC's ongoing role and impact in decision-making about Health Equity, health-related initiatives, cultural and linguistic services, resource allocation, and other community-based initiatives, including examples of how CAC input impacted and shaped Contractor initiatives and/or policies.

5.2.12 Continuity of Care for Seniors and Persons with Disabilities

A. For newly enrolled Seniors and Persons with Disabilities (SPD) who request continuity of care, Contractor must provide continued access for up to 12 months to an out-of-Network Provider with whom the SPD Member has an ongoing relationship, as long as Contractor has no Quality of Care issues with the Provider and the Provider will accept either Contractor's or the Medi-Cal FFS Rates, whichever is higher, pursuant to

W&I section 14182(b)(13) - (14). Contractor must use Medi-Cal FFS utilization data from DHCS to confirm that the SPD Member has an ongoing relationship with the Provider.

B. Contractor must allow all Members to request continuity of care in accordance with 42 CFR section 438.62 and APL 23-022.

C. Contractor must provide for the completion of Covered Services at the request of a Member in accordance with H&S section 1373.96. All Members with pre-existing Provider relationships who make a continuity of care request must be given the option to continue treatment for up to 12 months with an out-of-Network Provider, if the following criteria are met:

1) The Member has seen the out-of-Network Provider at least once within the 12 months before Enrollment with Contractor;

2) The out-of-Network Provider accepts Contractor's rate offered in accordance with H&S section 1373.96(d)(2) or (e)(2); and

3) The out-of-Network Provider meets Contractor's applicable professional standards and has no disqualifying Quality of Care issues.

D. Contractor must conduct Person-Centered Planning for SPD Members as follows:

1) Upon the Enrollment of a SPD Member, Contractor must provide, or ensure the provision of, Person-Centered Planning and treatment approaches that are collaborative and responsive to the SPD Member's continuing health care needs.

2) Contractor must include identifying each SPD Member's preferences and choices regarding treatments and services, and abilities.

3) Contractor must allow or ensure the participation of the SPD Member, and any family, friends, and professionals of their choosing, to participate fully in any discussion or decisions regarding treatments and services.

4) Contractor must ensure that SPD Members receive all necessary information regarding treatment and services so that they may make an informed choice.

5) Complex Case Management services for SPD Members must include the concepts of Person-Centered Planning.

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

1) Documentation of pre-admission status, including living arrangements, physical and mental function, social support, Durable Medical Equipment (DME), and other services received.

2) Documentation of pre-discharge factors, including an understanding of the medical condition by the SPD Member or an AR of the SPD Member as applicable, physical and mental function, financial resources, and social supports.

3) Services needed after discharge, the type of placement preferred by the SPD Member or their AR and hospital/institution, type of placement agreed to by the SPD Member or their AR, the specific agency or home recommended by the hospital, the specific agency or home agreed to by the SPD Member or their AR, and the pre-discharge counseling that is recommended.

4) Summary of the nature and outcome of the SPD Member's, or their AR's, involvement in the Discharge Planning process, anticipated problems in implementing post-discharge plans, and further action contemplated by the hospital or institution.

5.2.13 Network Reports

A. Network Certification Report

1) Contractor must submit its Network certification report to DHCS. The report must demonstrate Contractor's capacity to serve the current and expected membership for its Service Area in accordance with 42 CFR section 438.207(b), W&I section 14197(f)(1), and APL 23-001.

2) Contractor must demonstrate good faith compliance with contracting and referral requirements with certain cancer centers in accordance with W&I section 14197.45.

3) Contractor must demonstrate how it will arrange for Covered Services to Members through the use of NEMT, NMT, and Telehealth if Contractor does not meet time or distance standards for adult and pediatric PCPs, core Specialist and outpatient mental health Providers in accordance with W&I section 14197(f)(2).

4) Contractor must submit Network certification in accordance with the requirements placed upon DHCS pursuant to 42 CFR section 438.66(e). Contractor must submit its Network certification report as outlined in APL 23-001. As part of the Network certification report, Contractor must provide documentation demonstrating efforts to recruit new Providers to areas that do not meet time or distance standards without the use of an AAS request.

B. Periodic Reporting Requirements

1) Contractor must report to DHCS any time there is a Significant Change to Contractor's Network that affects Network capacity and Contractor's ability to provide health care services, such as the following:

a) Change in Covered Services or benefits;

b) Change in geographic Service Area;

c) Change in the composition of, or the payments to, its Network Providers, Subcontractors, or Downstream Subcontractors; or

d) Enrollment of a new population.

2) Contractor must provide supporting documentation detailing any Significant Change to DHCS. DHCS will determine what information Contractor must provide after Contractor reports a Significant Change to its Network pursuant to 42 CFR section 438.207.

C. Network Change Report

1) Contractor must submit to DHCS, in a format specified by DHCS, a report summarizing changes in the Network.

2) Contractor must submit the report 30 calendar days following the end of the reporting quarter.

D. Subcontractor and Downstream Subcontractor Network Certification Report

1) Contractor must develop, implement, and maintain a process to annually certify the Network(s) of its Subcontractor(s) and Downstream Subcontractor(s) that provide Medi-Cal Covered Services for compliance with Network Ratios set forth in Exhibit A, Attachment III, Subsection 5.2.4 (*Network Ratios*), Network Adequacy Standards set forth in Subsection 5.2.5 (*Network Adequacy Standards*), and Network Composition requirements set forth in Exhibit A, Attachment III, Subsection 5.2.3 (*Network Composition*) of this Contract in accordance with APL 23-006.

2) Contractor must submit complete and accurate Network Provider Subcontractor and Downstream Subcontractor Network Provider Data to confirm its Subcontractor Network(s) is compliant with all applicable network adequacy requirements, as set forth in Exhibit A, Attachment III, Subsection 2.1.4 (*Network Provider Data Reporting*).

3) Contactor must have a process in place to impose Corrective Action and sanctions and report to DHCS when Subcontractor and Downstream Subcontractors that provide Covered Services fail to meet Network adequacy standards as set forth in APL 23-006. Contractor must ensure all Members assigned to a Subcontractor or Downstream Subcontractor Network that is under a Corrective Action continue access to Medically Necessary Covered Services within timely access standards and applicable time or distance standards as set forth in Exhibit A, Attachment III, Subsection 5.2.5 (*Network Adequacy Standards*) by supplementing the Subcontractor or Downstream Subcontractor Network until the Corrective Action is resolved.

4) Contractor must submit Network certification in accordance with the requirements placed upon DHCS pursuant to 42 CFR section 438.66(e). Contractor must submit the results of its Subcontractor and Downstream Subcontractor Network Certification to DHCS in a format specified by DHCS and post its submitted certification on its website.

5.2.14 Site Review

A. General Requirement

1) Contractor must conduct Facility Site Reviews (FSR) and Medical Record reviews, initially and every three years, on all PCP sites in

accordance with APL 22-017. Contractor must ensure that Network Providers, Subcontractors, and Downstream Subcontractors have the capacity to provide Primary Care services, appropriate Preventive Care services, coordination and continuity of care in accordance with 42 CFR section 438.207.

2) Contractor must ensure that Network Providers provide physical access, reasonable accommodations, and accessible equipment for Members with physical or mental disabilities. Contractor must also conduct facility site physical accessibility reviews on PCP sites, Provider sites which serve a high volume of SPD Members, and all Provider sites including CBAS and ancillary service Providers, in accordance with Policy Letter (PL) 12-006 and W&I section 14182(b)(9).

B. Pre-Operational Site Reviews

The number of Site Reviews to be completed prior to initiating Contractor operation in a Service Area must be based upon the total number of new Primary Care sites in the Network. For more than 30 sites in the Network, a five (5) percent sample size or a minimum of 30 sites, whichever is greater in number, must be reviewed six (6) weeks prior to Contractor operation. Site Reviews must be completed on all remaining sites within six (6) months of Contractor operation. For 30 or fewer sites, reviews must be completed on all sites six (6) weeks prior to Contractor operation.

C. Credentialing Site Review

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

D. Corrective Action

Contractor must ensure that a Corrective Action plan is developed to correct cited deficiencies and that corrections are completed and verified within the established guidelines as specified in APL 22-017. PCP sites that do not correct cited deficiencies must be terminated from Contractor's Network; Contractor must assign Members to other Network Providers in accordance with APL 21-003.

E. Data Submission

Contractor must submit the Site Review data to DHCS up to quarterly, or in a manner or timeframe specified by DHCS. All data elements defined by DHCS must be included in the data submission report.

F. Continuing Oversight

Contractor must retain accountability for all Site Review activities even if this function is delegated.

G. Medical Record Documentation

1) General Requirement

Contractor must ensure the documentation of appropriate Medical Records for Members and that Medical Records are available to Providers at each Encounter in accordance with 42 USC section 1396a(w), 28 CCR section 1300.67.1(c), and APL 20-006.

2) Medical Records

Contractor must have policies and procedures for developing, implementing and maintaining written procedures for all forms of Medical Record retention including but not limited to:

a) For storage and filing of Medical Records including: collection, processing, maintenance, storage, retrieval, identification, and distribution;

b) To ensure that Medical Records are protected and confidential in accordance with all federal and State law;

c) For the release of information and obtaining consent for treatment; and

d) To ensure maintenance of Medical Records in a legible, current, detailed, organized and comprehensive manner (records may be electronic or paper copy).

3) On-Site Medical Records

Contractor must have policies and procedures to ensure that an individual is delegated the responsibility for securing and maintaining the security of Medical Records at each site.

4) Member Medical Record

Contractor must ensure that a complete, legible Medical Record is maintained for each Member in accordance with 22 CCR section 53861, which reflects all aspects of patient care, including, but not limited to, ancillary services, and at a minimum includes:

a) Member identification on each page; personal/biographical data in the record;

b) Member's preferred language (if other than English) prominently noted in the record, as well as the request or refusal of language/interpretation services in accordance with Title VI of the Civil Rights Act of 1964;

c) All entries dated with the author identified. For Member visits, all entries must include at a minimum, the documentation of subjective complaints, the objective findings, the plan for diagnosis and treatment, and follow-up care;

d) A problem list, a complete record of immunizations and health maintenance or preventive services rendered, and documentation of any outreach efforts surrounding any missed appointments;

e) Allergies and adverse reactions prominently noted;

f) All appropriate informed consent documentation, including the human sterilization consent procedures required by 22 CCR sections 51305.1 - 51305.6, if applicable;

g) Reports of Emergency Services provided (directly by the Network Provider or through an emergency room) and the hospital discharge summaries for all hospital admissions, including any follow-up after the provision of Emergency Services or hospitalizations;

h) Consultations and referrals, including for Complex Care Management (CCM), Enhanced Care Management, and Specialists, as well as evidence of review of specialty referrals, pathology, and laboratory reports. Any abnormal results must have an explicit notation in the Medical Record, including follow-up or outreach;

i) For Medical Records of adults, documentation of whether the individual has been informed and has executed an

Advance Directive, such as a durable power of attorney, for health care for Members ages 18 and over;

j) Health education behavioral assessment and referrals to health education services where appropriate; and

k) Documentation of blood lead screening, immunizations, and other preventive services provided in accordance with the American Academy of Pediatrics Bright Futures Periodicity Schedule, the United States Preventive Services Task Force Grade A and B recommendations, the American College of Obstetrics and Gynecologists, and the Advisory Committee on Immunization Practice recommendations. Member refusal to receive blood lead screening, immunizations, or other preventive services must also be documented in the Member's Medical Record as described in Exhibit A, Attachment III, Section 5.3 (*Scope of Services*).

5.2.15 Street Medicine

Contractor may provide medical and other Covered Services as described in APL 24-001 via a Street Medicine program for Members experiencing unsheltered homelessness through contracted Street Medicine Providers. Street Medicine Providers are Providers or entities that Contractor has determined can provide Street Medicine services to eligible Members in an effective manner consistent with Street Medicine industry protocols and practices. Street Medicine Providers may act in the role of the Member's assigned PCP, through a direct contract with Contractor, as an Enhanced Care Management (ECM) Provider, a Community Supports Provider, a referring or treating contracted Provider, or Community Health Worker as set forth in APL 24-001. This subsection refers only to Street Medicine programs and Street Medicine Providers that Contractor may choose to offer.

A. Contracted Street Medicine Providers acting in the role of a Member's assigned PCP are licensed physician and non-physician medical practitioners (e.g., Doctor of Medicine (MD)/Doctor of Osteopathic Medicine (DO), Physician Assistant (PA), NP, and CNM. For a non-physician medical practitioner (PA, NP, and CNM), Contractors must ensure compliance with State law and Contract requirements regarding physician supervision of non-physician medical practitioners. Additionally, given the unique and specialized nature of Street Medicine, a supervising Physician must be a practicing Street Medicine provider, with knowledge of, and experience in, Street Medicine clinical guidelines and protocols. Street Medicine Providers who choose to act as a Member's assigned PCP must agree to provide the essential components of the Medical Home in order to provide comprehensive and continuous medical care,

such as Basic Population Health Management; Care Coordination and health promotion; support for Members, their families, and their ARs; referrals to Specialists, including Behavioral Health, community, and social support services, when needed; use of Health Information Technology to link services, as feasible and appropriate; and provision of primary and preventative services to assigned Members. If the Street Medicine Provider does not have the capability to provide Primary Care services on the street, the Street Medicine Provider must be affiliated with a facility that has a physical location.

B. Contractor must ensure Street Medicine Providers have the capability to, and comply with, referral and Care Coordination, administrative, billing and claim, data sharing, and reporting requirements.

C. Contractor must ensure Street Medicine Providers acting in the capacity of an ECM and/or Community Supports Providers comply with requirements as set forth in APL 21-012 and/or other guidance. Contractor is to ensure Street Medicine Providers receive appropriate Provider training and manuals and have adequate systems in place to adhere to such requirements.

D. Contractor must submit contractually required policies and procedures exhibiting compliance with program policy and requirements, and receive approval from DHCS, before operating a Street Medicine program.

Exhibit A, ATTACHMENT III

5.3 Scope of Services

5.3.1 Covered Services
5.3.2 Medically Necessary Services
5.3.3 Initial Health Appointment
5.3.4 Services for Members Less Than 21 Years of Age
5.3.5 Services for Adults
5.3.6 Pregnant and Postpartum Members
5.3.7 Services for All Members
5.3.8 Investigational Services

5.3 Scope of Services

5.3.1 Covered Services

A. Contractor must provide or arrange for all Covered Services for Members, in accordance with the definition of Covered Services set forth in Exhibit A, Attachment I, Article 1.0 (*Definitions*). Contractor must ensure that Covered Services and other services required in this Contract are provided to a Member in an amount no less than what is offered to Medi-Cal beneficiaries in Medi-Cal Fee-For-Service (FFS), as defined in the most current Medi-Cal Provider Manual and consistent with current, evidence-based medical standards. Contractor has the primary responsibility to provide all Covered Services, including services that exceed the services provided by Local Education Agencies (LEAs), Regional Centers (RCs), or local governmental health programs.

B. Contractor must ensure that services provided are sufficient in amount, duration, and scope to reasonably achieve the purpose for which the Covered Services are furnished. Contractor must not arbitrarily deny or reduce the amount, duration, or scope of a required Covered Service solely because of the diagnosis, type of illness, or condition. Contractor may place appropriate limits on a Covered Service on the basis of Medical Necessity or utilization control for services that are not medical services (such as Community Support services), provided the services furnished are reasonably expected to achieve their purpose and are provided in a manner that reflects the Member's ongoing needs, including but not limited to services for chronic conditions.

C. Except as set forth in Attachment 3.1.B.1 of the California Medicaid State Plan or as otherwise authorized by Welfare and Institutions Code (W&I) section 14133.23, drug benefits for Members who are eligible for drug benefits under 42 United States Code (USC) section 1395w-101 *et seq*.) are not a Covered Service under this Contract. Contractor must comply with all applicable provisions of the Medicare Prescription Drug Improvement and Modernization Act of 2003, Policy Letter (PL) 108–173, December 8, 2003, 117 Stat 2066.

D. Unless expressly excluded under this Contract, Contractor must cover any services necessary for compliance with the requirements for parity in mental health and Substance Use Disorder (SUD) benefits, and ensure that Members are given access to all mental health and SUD services in accordance with 42 Code of Federal Regulations (CFR) section 438.900. The types, amount, duration, and scope of these services must be consistent with the parity compliance analysis conducted by either DHCS or Contractor.

1) If Contractor provides Members with mental health or SUD services in any classification of benefits as described in 42 CFR section 438.910(b)(2), then Contractor must provide to Members those services in every classification that is listed therein and is covered by Contractor. In determining the classification in which a particular benefit belongs, Contractor must apply the same reasonable standards for medical/surgical benefits to mental health or SUD benefits.

2) Contractor must provide referrals and Care Coordination for all non-covered mental health and SUD services, as required in Exhibit A, Attachment III, Subsections 4.3.12 (*Mental Health Services*) and 4.3.13 (*Alcohol and Substance Use Disorder Treatment Services*).

E. Covered Services may be provided to Members through Telehealth, as defined in W&I section 14132.72, and as follows:

1) Contractor is responsible for ensuring that Covered Services provided via a Telehealth modality meet DHCS guidelines in outlined in the Provider Manual.

2) Contractor must oversee that Providers only provide Covered Services that can be appropriately delivered via Telehealth, and that they not provide Covered Services that would otherwise require the in-person presence of the Member for any reason, such as those that are performed in an operating room or while the Member is under anesthesia, where direct visualization or instrumentation of bodily structures is required, or procedures that involve sampling of tissue or insertion/removal of medical devices.

3) Contractor must ensure all Providers furnishing applicable Covered Services via audio-only synchronous interactions also offer those same services via video synchronous interactions.

4) Contractor must ensure all Providers furnishing services through video synchronous interactions or audio-only synchronous interactions must do one of the following:

a) Offer those same services via in-person, face-to-face contact.

b) Arrange for a referral to, and a facilitation of, in-person care that does not require a Member to independently contact a different Provider to arrange for that care.

5) Contractor is responsible for ensuring Members are informed prior to the initial delivery of Covered Services via Telehealth about the use of Telehealth. Contractor must also ensure Providers obtain and document verbal or written consent from Members for the use of Telehealth as an acceptable mode of delivering services prior to the initial delivery of Covered Services. Consent must be documented in the Member's Medical Record and made available to DHCS upon request.

6) Contractor must communicate to Providers any periodical updates to Covered Services and Provider types and requirements that may be appropriately delivered through Telehealth.

5.3.2 Medically Necessary Services

Contractor must apply the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of Medical Necessity for Members less than 21 years of age, as set forth in 42 USC section 1396d(r)(5) and All Plan Letter (APL) 23-005. The terms Medically Necessary, or Medical Necessity, are defined in Exhibit A, Attachment I, Article 1.0 (*Definitions*), based upon whether a Member is less than 21 years of age, or ages 21 and over.

5.3.3 Initial Health Appointment

Contractor must ensure provision of an Initial Health Appointment (IHA) in accordance with 22 California Code of Regulations (CCR) sections 53851(b)(1), 53910.5(a)(1) and APL 22-030. An IHA at a minimum must include: a history of the Member's physical and mental health, an identification of risks, an assessment of need for preventive screens or services and health education, a physical examination, and the diagnosis and plan for treatment of any diseases, unless the Member's Primary Care Provider (PCP) determines that the Member's Medical Record contains complete information, updated within the previous 12 months, consistent with the assessment requirements. Contractor must continue to hold Network Providers accountable for providing all preventive screenings for adults and Children as recommended by the United States Preventive Services Taskforce (USPSTF) but will no longer require all these elements to be completed during the IHA, so long as Members receive all required screenings in a timely manner consistent with USPSTF guidelines.

A. Contractor must cover and ensure the provision of an IHA for each new Member within timelines stipulated in Exhibit A, Attachment III, Subsections 5.3.4 (*Services for Members Less Than 21 Years of Age*) and 5.3.5 (*Services for Adults*) below.

B. Contractor must ensure that a Member's completed IHA is documented in their Medical Record and that appropriate assessments from the IHA are available during subsequent health visits.

C. Contractor must make reasonable attempts to contact a Member to schedule an IHA. Contractor must document all attempts to contact a Member. Documented attempts that demonstrate Contractor's efforts to unsuccessfully contact a Member and schedule an IHA will be considered evidence in meeting this requirement. Contractor may delegate these activities, but Contractor remains ultimately responsible for all delegated functions, as outlined in Exhibit A, Attachment III, Subsection 3.1.1 (*Overview of Contractor's Duties and Obligations*).

5.3.4 Services for Members Less Than 21 Years of Age

Contractor must cover and ensure the provision of all screening, preventive and Medically Necessary diagnostic and treatment services for Members less than 21 years of age required under the EPSDT benefit described in 42 USC section 1396d(r), W&I section 14132(v), and APL 23-005. The EPSDT benefit includes all Medically Necessary health care, diagnostic services, treatments, and other services listed in 42 USC section 1396d(a), whether or not covered under the California Medicaid State Plan. All EPSDT services are Covered Services unless expressly excluded under this Contract.

A. Provision of IHA for Members Less Than 21 Years of Age

1) For Members less than 18 months of age, Contractor must ensure the provision of an IHA within 120 calendar days following the date of Enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP) Bright Futures for ages two and younger, whichever is sooner.

2) For Members ages 18 months and older, Contractor must ensure an IHA is performed within 120 calendar days of Enrollment.

3) The IHA must provide, or arrange for provision of, all immunizations necessary to ensure that the Member is up to date for their age, Adverse Childhood Experiences (ACEs) screening, and any required age-specific screenings including developmental screenings.

4) If the provisions of the IHA are not met, then Contractor must ensure case management and Care Coordination are working directly with the Member to receive appropriate services to include but not limited to health screenings, immunizations, and risk assessments.

B. Children’s Preventive Services

1) Contractor must provide preventive health visits for all Members less than 21 years of age at times specified by the most recent AAP Bright Futures Periodicity Schedule and anticipatory guidance as outlined in the AAP Bright Futures Periodicity Schedule. Contractor must provide, as part of the periodic preventive visit, all age-specific assessments and services required by AAP Bright Futures.

2) Where a request is made for Children’s preventive services by the Member, the Member's parent, legal guardian, or Authorized Representatives (ARs), or through a referral, an appointment must be made for the Member to have a visit within ten Working Days of the request, unless Member declines a visit within ten Working Days of the request and another appointment date is chosen by the Member.

3) At each Non-emergency Primary Care visit with a Member less than 21 years of age, the Member (if an emancipated minor), or the parent, legal guardian, or AR of the Member, must be advised of the Children’s preventive services due and available from Contractor. Documentation must be entered in the Member's Medical Record which indicates the receipt of Children’s preventive services in accordance with the AAP Bright Futures standards. If the services are refused, documentation must be entered in the Member's Medical Record which indicates the services were advised, and the Member’s (if an emancipated minor), or the parent, legal guardian, or AR of the Member’s voluntary refusal of these services.

4) All children’s preventive services, including all confidential screening and billing reports for EPSDT screening, treatment, and Care Coordination, must be reported as part of the Encounter Data submittal required in Exhibit A, Attachment III, Subsection 2.1.2 (*Encounter Data Reporting*). Contractor must ensure appropriate acquisition for missed reporting of Children’s preventive services.

C. Immunizations

1) Contractor must cover vaccinations, except for vaccinations expressly excluded in DHCS guidance to Medi-Cal Managed Care Health Plans, at the time of any health care visit and ensure the timely provision of vaccines in accordance with the most recent childhood immunization schedule and recommendations published by Advisory Committee on Immunization Practices (ACIP).

Documented attempts that demonstrate Contractor's unsuccessful efforts to provide the vaccination will be considered sufficient in meeting this requirement. When practical, reasons for failed attempts should be medically coded.

2) At each Non-Emergency Primary Care visit with Members less than 21 years of age, the Member (if an emancipated minor), or the parent, legal guardian, or AR of the Member, must be advised of the vaccinations due and available from Contractor immediately, if the Member has not received vaccinations in accordance with ACIP standards. Documentation must be entered in the Member's Medical Record which indicates the receipt of vaccinations or proof of prior vaccination in accordance with ACIP standards. If vaccinations that could be given at the time of the visit are refused, documentation must be entered in the Member's Medical Record which indicates the vaccinations were advised, and the Member's (if an emancipated minor), or the parent, legal guardian, or AR of the Member's voluntary refusal of these vaccinations. If vaccinations cannot be given at the time of the visit, then it is required that the Medical Record must demonstrate that the Member was informed how to obtain necessary vaccinations or scheduled for a future appointment for vaccinations.

3) Contractor must ensure that Member-specific vaccination information is reported to immunization registries established in Contractor's Service Area(s) as part of the Statewide Immunization Information System. Reports must be made following the Member's IHA and all other health care visits that result in an administered vaccine within 14 calendar days. Reporting must be in accordance with all applicable State and federal laws.

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

5) Contractor must provide information to all Network Providers regarding the VFC Program and is encouraged to promote and support Enrollment of applicable Network Providers in the VFC program as see appropriate.

D. Screening for Childhood Lead Poisoning

1) Contractor must cover and ensure the provision of blood lead screening tests to Members at the ages and intervals specified in 17 CCR sections 37000 - 37100, and in accordance with APL 20-016. Contractor must ensure its Network Providers follow the Childhood Lead Poisoning Prevention Branch (CLPPB) guidelines when interpreting blood lead levels and determining appropriate follow-up activities, including, without limitation, appropriate referrals to the local public health department.

   a) While requirements for appropriate follow-up activities, including referral, case management, and reporting, are set forth in the CLPPB guidelines, a Network Provider may determine that additional services that fall within the EPSDT benefit are Medically Necessary.

   b) Contractor must ensure that Members less than 21 years of age receive all Medically Necessary care as required under EPSDT.

2) Contractor must identify, at least quarterly, all Members less than six years of age with no record of receiving a required blood lead screening test. Contractor must identify the age(s) at which a required blood lead screening test was missed, including Members under the age of six, without any record of a completed blood lead screening test at each age. On a quarterly basis, Contractor must notify the Network Provider responsible for the care of an identified Member of the requirement to test the Member and provide the written or oral anticipatory guidance as required pursuant to 17 CCR section 37100. For a period of no less than ten years, Contractor must maintain records of all Members identified quarterly as having no documentation of receiving a required blood lead screening test, and provide those records to DHCS at least annually, as well as upon request.

3) If the Member, or the Member’s parent, legal guardian, or AR, refuses the blood lead screening test, Contractor must ensure a signed statement of voluntary refusal by the Member (if an emancipated minor), or the parent, legal guardian, or AR of the Member, is documented in the Member’s Medical Record.

4) If Contractor is unable to ensure a signed statement of voluntary refusal is documented in the Member's Medical Record because the Member, or the Member's parent, legal guardian, or AR refuses or declines to sign, or is unable to sign, such as when services are

provided through a Telehealth modality, Contractor must ensure that the reason for not obtaining a signed statement of voluntary refusal is documented in the Member's Medical Record.

5) DHCS will consider unsuccessful attempts to provide the required blood lead screening tests that are documented in the Member's Medical Record in accordance with the requirements in Exhibit A, Attachment III, Subsection 5.3.4.D. (*Services for Members Less Than 21 Years of Age*) as evidence of Contractor's compliance with blood lead screening test requirements.

E. EPSDT Services

1) For Members less than 21 years of age, Contractor must comply with all requirements identified in APL 23-005. Contractor must provide, or arrange and pay for, all Medically Necessary EPSDT services, including all Medicaid services listed in 42 USC section 1396d(a), whether or not included in the California Medicaid State Plan, unless expressly excluded in this Contract. Covered Services will include, without limitation, in-home nursing provided by home health agencies or individual nurse Providers, as required by APL 20-012, Care Coordination, case management, and Targeted Case Management (TCM) services. If Members less than 21 years of age are not eligible or accepted for Medically Necessary TCM services by a RC or local government health program, per requirements in Exhibit A, Attachment III, Section 5.6 (*MOUs with Local Government Agencies, County Programs, and Third Parties*), Contractor must arrange for comparable services for the Member under the EPSDT benefit in accordance with APL 23-005.

2) Contractor must arrange for any Medically Necessary diagnostic and treatment services identified at a preventive screening or other visit indicating the need for diagnosis or treatment, either directly or through referral to appropriate agencies, organizations, or individuals, as required by 42 USC section 1396a(a)(43)(C), APL 23-005, and APL 20-012. Contractor must ensure that all Medically Necessary EPSDT services, including all Covered Services set forth in Exhibit A, Attachment III, Subsection 5.3.4.E.1) (*Services for Members Less Than 21 Years of Age*), above, as well as EPSDT services carved out of this Contract, are provided in a timely manner, as soon as possible but no later than 60 calendar days following the preventive screening or other visit identifying a need for diagnosis or treatment. Without limitation, Contractor must identify available Providers, including if necessary out-of-Network Providers and individuals eligible to enroll as Medi-Cal Providers, to ensure the timely provision of Medically Necessary EPSDT

services. Contractor must provide appointment scheduling assistance and necessary transportation, including Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT), to and from medical appointments for Covered Services and pharmacy services. NMT must also be provided for services not covered under this Contract.

3) Covered Services do not include California Children's Services (CCS), pursuant to Exhibit A, Attachment III, Subsection 4.3.14 (*California Children's Services*), or Specialty Mental Health Services (SMHS), pursuant to Exhibit A, Attachment III, Subsection 4.3.12 (*Mental Health Services*). Contractor must ensure that the case management for Medically Necessary services authorized by CCS, county mental health plans, Drug Medi-Cal or Drug Medi-Cal Organized Delivery System (DMC-ODS)Plans under this Subsection is equivalent to that provided by Contractor for Covered Services for Members less than 21 years of age under this Contract and must, if indicated or upon the Member's request, provide additional Care Coordination and case management services as necessary to meet the Member's medical and Behavioral Health needs.

F. Behavioral Health Treatment Services

For Members less than 21 years of age, Contractor must cover Medically Necessary Behavioral Health Treatment (BHT) services regardless of diagnosis in compliance with APL 26-002 and APL 23-010.

1) Contractor must provide Medically Necessary BHT services in accordance with a recommendation from a licensed physician, surgeon, or a licensed psychologist and must provide continuation of BHT services under continuity of care.

2) The Member's treatment plan must be reviewed, revised, and/or modified no less than every six months by a BHT service Provider. The Member's behavioral treatment plan may be modified or discontinued only if it is determined that the services are no longer Medically Necessary under the EPSDT Medical Necessity standard.

3) Contractor has primary responsibility for the provision of Medically Necessary BHT services and must coordinate with LEAs, RCs, and other entities that provide BHT services to ensure that Members timely receive all Medically Necessary BHT services, consistent with the EPSDT benefit. Contractor must provide Medically Necessary BHT services across settings, including home, school,

and in the community, that are not duplicative of BHT services actively provided by another entity. Contractor must coordinate with, and make good faith attempts to enter into Memorandum of Understandings (MOUs) with RCs and LEAs, and Contractor must enter into MOUs with County Mental Health Plans (MHPs) in accordance with Exhibit A, Attachment III, Subsection 5.6.1 (*MOU Purpose*), to facilitate the coordination of services for Members with Developmental Disabilities, including Autism Spectrum Disorder (ASD), as permitted by federal and State law, and specified by DHCS in APL 22-005 and APL 26-002. If Contractor is unable to enter into an MOU or a one-time case agreement with a RC, Contractor must inform DHCS why it could not reach an agreement with the RC and must demonstrate, by providing all evidence of contracting efforts, a good faith effort to enter into an agreement with the RC.

G. Local Education Agency Services

Contractor must reimburse LEAs, as appropriate, for the provision of school-linked EPSDT services including but not limited to BHT as specified in Exhibit A, Attachment III, Subsection 4.3.16 (*School-Based Services).*

H. Rapid Whole Genome Sequencing

Rapid whole genome sequencing, including individual sequencing, trio sequencing for a parent or parents and their baby, and ultra-rapid sequencing, is a Covered Service for any Medi-Cal Member who is one year of age or younger and is receiving inpatient hospital services in an intensive care unit as required in W&I section 14132(a)(e).

5.3.5 Services for Adults

A. Initial Health Appointment for Adults Ages 21 and over

1) Contractor must cover and ensure that IHAs for adult Members are performed within 120 calendar days of Enrollment.

2) Contractor must ensure that the IHA for adults includes, but is not limited to, an evaluation of applicable preventive services provided in accordance with the United States Preventive Services Taskforce (USPSTF) grade A and B recommendations.

B. Adult Preventive Services

Contractor must cover and ensure the provision of all preventive services and Medically Necessary diagnostic and treatment services for adult Members as follows:

1) Contractor must ensure provision of all applicable preventive services identified as USPSTF grade A and B recommendations for adult Members in accordance with the Guide to Clinical Preventive Services published by the USPSTF.

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

3) Contractor must comply with APL 22-025 and ensure the provision of an annual cognitive health assessment for Members who are 65 years of age or older and are otherwise ineligible to receive a similar assessment as part of a Medicare annual wellness visit.

C. Immunizations

1) Contractor must cover vaccinations, except for vaccinations expressly excluded by DHCS in guidance to Medi-Cal Managed Care Health Plans, at the time of any health care visit and ensure the timely provision of vaccines in accordance with the most recent adult immunization schedule and recommendations published by the ACIP. Documented attempts that demonstrate Contractor’s unsuccessful efforts to provide the vaccination will be considered sufficient in meeting this requirement.

2) In addition, Contractor must cover and ensure the provision of age and risk appropriate vaccinations in accordance with the findings of the IHA, or other preventive screenings.

3) At each non-emergency Primary Care Encounter the Member must be advised of the vaccinations due and available from Contractor, if the Member has not received vaccinations in accordance with ACIP standards. Documentation must be entered in the Member's Medical Record which indicates the receipt of vaccinations or proof of prior vaccination in accordance with ACIP standards. If vaccinations that could be given at the time of the visit are refused, documentation must be entered in the Member's Medical Record which indicates the vaccinations were advised, and the Member’s

voluntary refusal of these vaccinations. If vaccinations cannot be given at the time of the visit, then it is required that the Medical Record must demonstrate that the Member was informed how to obtain necessary vaccinations or scheduled for a future appointment for vaccinations.

4) Contractor must ensure that Member-specific vaccination information is reported to immunization registries established in Contractor's Service Area(s) as part of the Statewide Immunization Information System. Reports will be made following the Member's IHA and all other health care visits that result in an administered vaccine within 14 calendar days. Reporting will be in accordance with all applicable State and federal laws.

5.3.6 Pregnant and Postpartum Members

A. Prenatal and Postpartum Care

Contractor must cover and ensure the provision of all Medically Necessary services for Members who are pregnant and postpartum. Contractor must utilize the most current standards or guidelines of American College of Obstetricians and Gynecologists (ACOG) and Comprehensive Perinatal Services Program (CPSP) to ensure Members receive quality perinatal and postpartum services.

B. Risk Assessment

Contractor must implement a comprehensive risk assessment tool for all pregnant Members that is comparable to the ACOG standard and CPSP standards per 22 CCR section 51348. Contractor must maintain the results of this assessment as part of the Member's obstetrical record, which must include medical/obstetrical, nutritional, psychosocial, and health education needs risk assessment components. The risk assessment tool must be administered at the initial prenatal visit, once each trimester thereafter, and at the postpartum visit. If administration of the risk assessment tool is missed at the appropriate timeframes, then Contractor must ensure case management and Care Coordination are working directly with the Member to accomplish the assessment. Contractor must follow up on all identified risks with appropriate interventions consistent with ACOG standards and CPSP standards and document those interventions in the Member's Medical Record. The risk assessment may be completed virtually through a Telehealth visit with the Member's consent.

C. Referral to Specialists

Contractor must ensure that pregnant Members are referred to medically appropriate Specialists, including, as appropriate, perinatologists, Freestanding Birthing Centers, Certified Nurse Midwives (CNMs), Licensed Midwives, and, are informed about Doula coverage. Pregnant Members may request and receive a recommendation for Doula services from a physician or other licensed practitioner of the healing arts acting within their scope of practice under State law and receive services. Contractor must ensure that pregnant and postpartum Members receive a recommendation for Doula services within one year after pregnancy, if requested by the Member, and must ensure access to genetic screening with appropriate referrals. Members may receive one initial visit; eight visits at any time during the perinatal period; services during labor and delivery, miscarriage, or abortion; and two extended postpartum visits with the standing recommendation issued by DHCS. An additional nine visits during the postpartum period is available with a second recommendation from a licensed provider. Contractor must comply with section 440.130(c) of Title 42 of the Code of Federal Regulations when making a recommendation for Doula services. Doula services are a preventive benefit for Medi-Cal Members, and services include but are not limited to personal support to pregnant individuals and families throughout pregnancy, labor, and the postpartum period. Contractor must also ensure that appropriate hospitals are available within the Network to provide necessary high-risk pregnancy services.

5.3.7 Services for All Members

A. Health Education

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

2) Contractor must ensure administrative oversight of the health education system by a qualified full-time health educator.

3) Contractor must provide evidence-based health education programs and services to Members, directly, or through Subcontractors, Downstream Subcontractors, or Network Providers.

4) Contractor must ensure organized delivery of health education programs using educational strategies and methods that are appropriate for Members and effective in achieving behavioral change for improved health. Contractor may offer Members non-

monetary incentives for participating in incentive programs, focus groups, and Member surveys authorized by W&I section 14407.1 pursuant to APL 16-005.

5) Contractor must ensure that health education materials are written at the sixth-grade reading level and are culturally and linguistically appropriate for the intended audience in accordance with APL 18-016. Contractor must review health education materials to ensure documents are up-to-date.

6) Contractor must ensure availability of Community Health Workers (CHWs) to all Members. CHWs should provide services to include but are not limited to assisting Members with health care system navigation, communicating cultural and language preferences to providers, accessing health care services, educating health needs, and connecting individuals and families with community-based resources.

7) Contractor must maintain a health education system, or use a DHCS-sponsored system if available, that provides educational interventions addressing health categories and topics that align with the Population Health Management (PHM) Strategy, in accordance with Exhibit A, Attachment III, Section 4.3 (*Population Health Management and Coordination of Care*), including education regarding the appropriate use of health care services, risk-reduction and healthy lifestyles, and self-care and management of health conditions.

8) Contractor must ensure that Members receive point of service education as part of preventive and primary health care visits. Contractor must provide education, training, and program resources to Network Providers for the delivery of health education services.

9) Contractor must maintain health education policies, procedures, standards, and guidelines. Contractor must maintain documentation that demonstrates effective implementation of the health education requirements.

10) Contractor must monitor the health education system including accessibility for Limited English Proficient (LEP) Members and the performance of Providers that are contracted to deliver health education services. Contractor must ensure appropriate allocation of health education resources and conduct appropriate levels of program evaluation.

B. Hospice Care

1) Contractor must cover and ensure the provision of hospice care services as defined in 42 USC section 1396d(o)(1) and as required by APL 25-008. Contractor must ensure that Members and their families are fully informed of the availability of hospice care as a Covered Service and the methods by which they may elect to receive these services. In accordance with APL 25-008, a hospice must obtain written physician certification of terminal illness for each hospice benefit period; as well as face-to-face encounter requirements for applicable benefit periods. “Terminally ill,” as defined in 42 CFR section 418.3, means that an individual has a medical prognosis that their life expectancy is six months or less if the illness runs its normal course. Services are limited to Members who directly or through their AR voluntarily elect to receive hospice care in lieu of curative care for the terminal illness as specified. However, for Members less than 21 years of age, a voluntary election of hospice care does not constitute a waiver of any rights of that Member to be provided with, or to have payment made for, Covered Services that are related to the treatment of that Member’s condition for which a diagnosis of terminal illness has been made.

2) For Members who have elected hospice care, Contractor must arrange for continuity of care, including maintaining established patient-Provider relationships, to the greatest extent possible. Contractor must cover the cost of all hospice care provided. Contractor must also cover all Medically Necessary care not related to the terminal condition.

C. Palliative Care

Contractor must cover and ensure the provision of palliative care, as required by W&I section 14132.75 and as set forth in APL 18-020, and as required for Members less than 21 years of age under the EPSDT benefit and standard of Medical Necessity. Contractor must continue to cover all Medically Necessary Covered Services for Members receiving palliative care. For Members less than 21 years of age, Contractor must cover palliative care concurrently with hospice care and other Medically Necessary Covered Services if hospice care is elected by the Member.

D. Vision Care – Lenses

Contractor must cover and ensure the provision of eye examinations to include screening examinations and prescriptions for corrective lenses as appropriate for all Members. Contractor must arrange for the fabrication of

optical lenses for Members through Prison Industry Authority (PIA) optical laboratories except when the Member requires lenses not available through PIA. Contractor must cover the cost of the eye examination and dispensing of the lenses fabricated by PIA. DHCS will reimburse PIA for the fabrication of the optical lenses in accordance with the contract between DHCS and PIA. Contractor must cover the cost of fabrication and dispensing of lenses not available through PIA.

E. Mental Health and SUD Services

Contractor must cover all Medically Necessary mental health and SUD services specified in Exhibit A, Attachment III, Subsection 5.5.2 (*Non-Specialty Mental Health Services and Substance Use Disorder Services*) in compliance with mental health parity requirements in 42 CFR section 438.900 *et seq*., and Exhibit A, Attachment III, Section 5.5 (*Mental Health and Substance Use Disorder Benefits*).

F. Organ and Bone Marrow Transplant Surgeries

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

1) Contractor must refer and authorize organ and bone marrow transplant surgeries to be performed in transplant programs that meet criteria set forth by DHCS in the Medi-Cal Provider Manual.

2) Contractor must authorize and cover costs for organ or bone marrow transplants for Members. Contractor must cover all pre and post-operative transplant-related costs such as, but not limited to, evaluation, hospitalization, and all Medically Necessary services such as transportation and prescriptions not covered by and billable to Medi-Cal Rx.

3) Contractor must refer Members identified as potential organ or bone marrow transplant candidates to a transplant program evaluation that meets criteria set forth by DHCS within 72 hours of receiving the referral. If the transplant program considers the Member to be a suitable transplant candidate, Contractor must authorize the request for transplant services on an expedited 72-hour basis or less if the Member’s condition requires it, or if the organ or bone marrow the Member will receive is at risk of being unusable due to any delay in obtaining Prior Authorization or any delay in obtaining the organ or bone marrow.

4) Contractor must refer Members less than 21 years of age identified as a potential organ or bone marrow transplant candidate to the local CCS Program for eligibility determination, if necessary, unless Contractor is responsible for the CCS benefit (Whole Child Model contracts only). Major Organ Transplants (MOT) for Members less than 21 years of age must be performed only in a CCS-approved Special Care Center (SCC) or DHCS-approved Transplant Centers of Excellence. If the CCS Program determines that the Member is not eligible for the CCS Program or the MOT is not related to the Member's CCS eligible medical condition, but the MOT is Medically Necessary, Contractor must refer the Member to a transplant program within 72 hours of receipt of the eligibility determination and is responsible for authorizing the MOT, as appropriate.

5) Contractor must refer CCS-eligible Members less than 21 years of age to the appropriate CCS-approved Special Care Center that meets criteria set forth by DHCS within 72 hours of receiving the referral from the Member's PCP or Specialist identifying the Member as a transplant candidate. If the CCS-approved Special Care Center considers the Member to be a suitable transplant candidate, Contractor is required to approve the Prior Authorization request.

6) For Members less than 21 years of age, Contractor must provide Prior Authorization for requests for transplant services on an expedited, 72-hour basis, or less if the Member's condition requires it or if the organ or bone marrow the Member will receive is at risk of being unusable due to any delay in obtaining Prior Authorization or any delay in obtaining the organ or bone marrow.

7) Contractor must authorize and cover costs for organ or bone marrow donors, including cadavers and living donors regardless of a living donor's Medi-Cal eligibility. Contractor must cover transplant-related costs such as evaluation, hospitalization for the living donor, organ or bone marrow removal, and all Medically Necessary services related to organ or bone marrow removal including complications, transportation, and prescriptions not covered by and billable to Medi-Cal Rx.

8) Contractor must ensure coordination of care between all Providers, organ or bone marrow donation entities, and transplant centers to ensure the transplant is completed as expeditiously as possible. This coordination of care must include care for all living donors.

9) Contractor must ensure the provision of Discharge Planning as defined in this Contract for Members and living donors.

10) Contractor must cover all readmissions and other health care costs related to any complications the Member or the living donor experiences from the organ or bone marrow transplant.

11) Contractor must cover all Medically Necessary physician administered drugs provided to a Member or the living donor administered by a health care professional in a clinic, physician's office, or outpatient setting and is needed for the Member receiving an organ or bone marrow transplant, such as anti-rejection medication, and any other Medically Necessary Prescription Drug not covered by Medi-Cal Rx.

G. Long-Term Care Services

Contractor must authorize and cover Long-Term Care (LTC) services as set forth in APL 23-004, APL 23-023, and APL 23-027. Contractor must ensure that Members in need of LTC services are placed in a health care facility that provides the level of care most appropriate to the Member's medical needs, unless the Member has elected hospice care.

1) Contractor must ensure that Members, other than Members requesting hospice services, in need of LTC services are placed in a LTC facility that provides the level of care most appropriate to the Member's medical needs. Contractor must make Member placement decisions based on the appropriate level of care, as set forth in the definitions in 22 CCR sections 51118, 51120, 51120.5, 51121, 51123, 51124, 51124.5, and 51124.6, W&I section 14132.25 and the criteria for admission set forth in 22 CCR sections 51335, 51335.5, 51335.6, and 51334 and related sections of the Manual of Criteria for Medi-Cal Authorization referenced in 22 CCR section 51003(e).

2) Contractor must place Members in LTC facilities that are licensed and certified by the California Department of Public Health (CDPH). Contractor must ensure that contracted LTC facilities have not been decertified by CDPH or otherwise excluded from participation in the Medi-Cal Program.

3) Contractor must provide continuity of care to Members through continued access to the LTC facility in which the Member is residing at time of Enrollment for up to 12 months. During this time, Contractor may attempt to place Members at LTC facilities within its Network only with approval from the Member or individual authorized to make health care decisions on their behalf.

4) Contractor must cover a Member stay in a facility with availability regardless of Medical Necessity if placement in a Medically Necessary appropriate lower level of care is not available, unless otherwise provided by contract. Contractor must continue to attempt to place the Member in a facility with the appropriate level of care, including offering to contract with facilities within and outside of the Service Area.

5) Contractor must provide Transitional Care Services as specified in Exhibit A, Attachment III, Subsection 4.3.11 (*Targeted Case Management Services*).

6) Hospice Services as defined in 22 CCR section 51180 rendered in a Skilled Nursing Facility (SNF) or Intermediate Care Facility for the Developmentally Disabled (ICF/DD), ICF/DD-Habilitative (ICF/DD-H), and ICF/DD-Nursing (ICF/DD-N) homes are not LTC services consistent with 22 CCR section 51544(h).

7) Contractor must ensure that Members in need of ICF/DD, ICF/DD-H, and ICF/DD-N services are placed in the ICF/DD Home deemed most appropriate to the Member's medical needs as specified in the Individualized Program Plan (IPP) issued by the Member's Regional Center.

H. Pharmaceutical Services

1) Drug Use Review (DUR)

Contractor must develop and implement effective DUR and treatment outcome process, as directed in APL 17-008, APL 23-026, and APL 25-013 (excluding prospective DUR activities), to ensure that drug utilization is appropriate, Medically Necessary, and not likely to result in adverse events.

a) Contractor's DUR must meet or exceed the requirements described in 42 USC section 1396r-8(g) and 42 CFR section 438.3(s), to the extent that Contractor provides covered outpatient drugs, and Section 1004 requirements of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patient and Communities Act.

b) Contractor's DUR must implement:

i. A retrospective claims review automated process that monitors when a Member is concurrently prescribed

opioids and benzodiazepines or opioids and antipsychotics;

ii. A program to monitor and manage the appropriate use of antipsychotic medications by all Children 18 years of age and under including foster Children enrolled under the California Medicaid State Plan, as required in 42 USC section 1396a(oo)(1)(B), APL 23-026, and APL 25-013; and

iii. Fraud and abuse identification processes for potential Fraud or abuse of controlled substances by Members, Providers, and pharmacies.

c) Contractor must annually submit to DHCS a detailed report in a format specified by DHCS on their DUR Program activities.

2) Contractor must not impose Quantitative Treatment Limitation (QTL) or Non-Quantitative Treatment Limitation (NQTL) more stringently for mental health and SUD drugs prescriptions than for medical/surgical drugs, in accordance with 42 CFR section 438.900 *et seq*.

I. Transportation

Contractor must cover transportation services as required in this Contract and directed in APL 22-008 to ensure Members have access to all Medically Necessary services.

1) Contractor must cover Emergency Medical Transportation (EMT) services necessary to provide access to all emergency Covered Services.

2) Contractor must cover NEMT services necessary for Members to access Covered Services, subject to a prescription and Prior Authorization when required, in accordance with 22 CCR section 51323.

a) Contractor must require Members to have an approved Physician Certification Statement (PCS) form prescribing NEMT by their provider, as described in APL 22-008, before Prior Authorization can be granted for NEMT services, except as provided in 22 CCR section 51323 (b)(2)(A),(C). For Covered Services requiring recurring appointments, Contractor must provide authorization for NEMT for the

duration of the recurring appointments, not to exceed 12 months, and ensure the Member has a standing order guaranteeing assigned rides for the duration of the recurring appointments. Contractor cannot modify the form once the provider prescribes the mode of NEMT.

b) Contractor must refer and coordinate NEMT services for Medi-Cal services that are not covered under the Contract. However, Contractor must provide NEMT services for their Members for all pharmacy prescriptions prescribed by the Member's Medi-Cal provider(s) and those authorized under Medi-Cal Rx.

c) Contractor must have a process in place to ensure transportation brokers and providers are meeting these requirements and to impose corrective action if non-compliance is identified through oversight and monitoring activities.

3) As provided for in W&I section 14132(ad), Contractor must authorize all NMT for Members to obtain Covered Services in accordance with the requirements and guidelines set forth in APL 22-008. Nothing in this provision will be construed to prohibit Contractor from developing policies and procedures that may include reasonable Utilization Management procedures for NMT. Contractor must also provide NMT for all Medi-Cal services not covered under this Contract. These services include, but are not limited to, Specialty Mental Health Service (SMHS), SUD services, dental, pharmacy, pharmaceutical services, and any other benefits delivered through Medi-Cal FFS.

4) Contractor must provide NEMT or NMT for a parent, legal guardian, or AR when the Member is a minor. With the written consent of a parent, legal guardian, or AR, Contractor may arrange NEMT or NMT services for a minor who is unaccompanied by a parent, legal guardian, or AR. Contractor must provide transportation services for unaccompanied minors when applicable State or federal law does not require parental consent for the minor's service. Contractor must ensure all necessary written consent forms are collected prior to arranging transportation for an unaccompanied minor and cannot arrange NEMT or NMT services for an unaccompanied minor without the necessary consent forms unless State or federal law does not require parental consent for minor's service.

5) Consistent with 42 CFR sections 440.170(a) and 431.53, W&I section 14132(a) and (d), and APL 22-008, Contractor must also cover transportation-related travel expenses for Members obtaining Medically Necessary services. Transportation-related travel expenses are subject to retroactive reimbursement.

J. Care Management and Care Coordination

1) Contractor must provide all Members with Care Coordination services as specified in Exhibit A, Attachment III, Subsection 4.3.8 (*Basic Population Health Management*).

2) Contractor must provide care management services to all Members as specified in Exhibit A, Attachment III, Subsection 4.3.8 (*Basic Population Health Management*) and Exhibit A, Attachment III, Subsection 4.3.7 (*Care Management Programs*). Care management services include Basic Population Health Management (Basic PHM), Complex Care Management (CCM), and Enhanced Care Management (ECM).

K. Dyadic Services

Contractor must provide Dyadic Services and the Family Therapy benefit for Members less than 21 years of age and/or their caregivers in an outpatient setting as Medically Necessary as set forth in APL 22-029 and detailed below.

1) Dyadic Services may be provided by Licensed Clinical Social Workers, Licensed Professional Clinical Counselors, Licensed Marriage and Family Therapists, Licensed Psychologists, Psychiatric Physician Assistants, Psychiatric Nurse Practitioners, and Psychiatrists. Associate Marriage and Family Therapists, Associate Professional Clinical Counselors, Associate Clinical Social Workers, and Psychology Assistants may render services under a supervising clinician. Appropriately trained nonclinical staff, including CHWs, are not precluded from screening Members for issues related to SDOH or performing other nonclinical support tasks as a component of the Dyadic Behavioral Health (DBH) visit, as long as the screening is not separately billed.

a) Under the supervision of a supervising Provider from one of the provider types listed above, CHWs can assist a dyad to gain access to needed services to support their health through the CHW benefit for health navigation services.

b) Contractor is responsible for ensuring appropriate supervision of Dyadic Services Providers and educating all Network Providers on the Dyadic Services benefit.

2) Member Eligibility for Dyadic Services

a) Children and their parent(s)/ caregiver(s) are eligible for DBH well-Child visits when delivered according to the Bright Futures/American Academy of Pediatrics periodicity schedule for behavioral/social/emotional screening assessment, and when medically necessary, in accordance with Medi-Cal's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standards in 42 USC section 1396d(r).

i. Under EPSDT standards, a diagnosis is not required to qualify for services.

ii. The DBH well-Child visits do not need a particular recommendation or referral and must be offered as an appropriate service option even if the Member does not request them.

b) The family is eligible to receive Dyadic Services so long as the Child is enrolled in Medi-Cal. The parent(s) or caregiver(s) does not need to be enrolled in Medi-Cal or have other coverage so long as the care is for the direct benefit of the Child.

3) Covered Services

a) Contractor may offer the Dyadic Services benefit through Telehealth or in-person with locations in any setting including, but not limited to, pediatric Primary Care settings, doctor's offices or clinics, inpatient or outpatient settings in hospitals, the Member's home, school-based sites, or community settings. There are no Service Location limitations.

b) Covered Dyadic Services are Behavioral Health Services for Children and/or their parent(s) or caregiver(s), and include:

i. DBH Well-Child Visits

a. The DBH well-Child visit must be limited to those services not already covered in the

medical well-Child visit.

b. When possible and operationally feasible, the DBH well-Child visit should occur on the same day as the medical well-Child visit. When this is not possible, Contractors must ensure the DBH well-Child visit is scheduled as close as possible to the medical well-Child visit, consistent with timely access requirements.

c. Contractor may deliver DBH well-Child visits as part of the HealthySteps program, a different DBH program, or in a clinical setting without a certified DBH program as long as all of the following components are included:

   aa. Behavioral Health history for Child and parent(s) or caregiver(s), including parent(s) or caregiver(s) interview addressing Child's temperament, relationship with others, interests, abilities, and parent or caregiver concerns.

   bb. Developmental history of the Child.

   cc. Observation of behavior of Child and parent(s) or caregiver(s) and interaction between Child and parent(s) or caregiver(s).

   dd. Mental status assessment of parent(s) or caregiver(s).

   ee. Screening for family needs, which may include tobacco use, substance use, utility needs, transportation needs, and interpersonal safety, including guns in the home.

   ff. Screening for SDOH such as poverty, food insecurity, housing instability, access to safe drinking water, and community level violence.

gg. Age-appropriate anticipatory guidance focused on Behavioral Health promotion/risk factor reduction.

hh. Making essential referrals and connections to community resources through Care Coordination and helping caregiver(s) prioritize needs.

ii. Dyadic Comprehensive Community Supports Services, separate and distinct from the California Advancing and Innovating Medi-Cal (CalAIM) Community Supports, help the Child and their parent(s) or caregiver(s) gain access to needed medical, social, educational, and other health-related services, and may include any of the following:

a. Assistance in maintaining, monitoring, and modifying covered services, as outlined in the dyad's service plan, to address an identified clinical need.

b. Brief telephone or face-to-face interactions with a person, family, or other involved member of the clinical team, for the purpose of offering assistance in accessing an identified clinical service.

c. Assistance in finding and connecting to necessary resources other than covered services to meet basic needs.

d. Communication and coordination of care with the Child's family, medical and dental health care Providers, community resources, and other involved supports including educational, social, judicial, community and other State agencies.

e. Outreach and follow-up of crisis contacts and missed appointments.

f. Other activities as needed to address the dyad's identified treatment and/or support needs.

c) Dyadic Psychoeducational Services for psychoeducational services provided to the Child less than 21 years of age and/or parent(s) or caregiver(s). These services must be planned, structured interventions that involve presenting or demonstrating information with the goal of preventing the development or worsening of Behavioral Health conditions and achieving optimal mental health and long-term resilience.

d) Dyadic Family Training and Counseling for Child Development for family training and counseling provided to both the Child less than 21 years of age and parent(s) or caregiver(s). These services include brief training and counseling related to a Child's behavioral issues, developmentally appropriate parenting strategies, parent/Child interactions, and other related issues.

e) Dyadic Parent or Caregiver Services

Dyadic parent or caregiver services are services delivered to a parent or caregiver during a Child's visit that is attended by the Child and parent or caregiver, including the following assessment, screening, counseling, and brief intervention services provided to the parent or caregiver for the benefit of the Child as appropriate:

i. Brief Emotional/Behavioral Assessment

ii. ACEs Screening

iii. Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment

iv. Depression Screening of Health Behavior Assessments and Interventions

v. Psychiatric Diagnostic Evaluation

vi. Tobacco Cessation Counseling

4) Family Therapy as a Behavioral Health Benefit

a) Family therapy is type of psychotherapy covered under Medi-Cal's NSMHS benefit, including for Members less than 21 years of age who are at risk for Behavioral Health concerns and for whom clinical literature would support that

the risk is significant such that Family Therapy is indicated, but may not have a mental health diagnosis. The primary purpose of Family Therapy is to address family dynamics as they relate to the Member's mental status and behavior(s).

b) Family Therapy is composed of at least two family members receiving therapy together provided by a mental health Provider to improve parent/Child or caregiver/Child relationships and encourage bonding, resolving conflicts, and creating a positive home environment.

c) All family members do not need to be present for each service. For example, parents or caregivers can qualify for Family Therapy without their infant present, if necessary.

d) Both Children and adult Members can receive Family Therapy mental health services that are medically necessary. Contractor is required to provide Family Therapy to the following Medi-Cal Members to improve parent/Child or caregiver/Child relationships and bonding, resolve conflicts, and create a positive home environment:

    i. Members less than 21 years of age with a diagnosis of a mental health disorder;

    ii. Members less than 21 years of age with persistent mental health symptoms in the absence of a mental health disorder;

    iii. Members less than 21 years of age with a history of at least one of the following risk factors:

        a. Neonatal or pediatric intensive care unit hospitalization;

        b. Separation from a parent or caregiver (for example, due to incarceration, immigration, or military deployment);

        c. Death of a parent or caregiver of Foster home placement;

        d. Food insecurity, housing instability;

        e. Maltreatment;

f. Severe and persistent bullying; and

g. Experience of discrimination, including but not limited to discrimination on the basis of race, ethnicity, gender identity, sexual orientation, religion, learning differences, or disability;

iv. Members less than 21 years of age who have a parent(s) or caregiver(s) with one or more of the following risk factors:

a. A serious illness or disability;

b. A history of incarceration;

c. Depression or other mood disorder;

d. Post-Traumatic Stress Disorder or other anxiety disorder;

e. Psychotic disorder under treatment;

f. SUD;

g. Job loss;

h. A history of intimate partner violence or interpersonal violence; and

i. Is a teen parent.

e) Contractor must provide Family Therapy services if needed to correct or ameliorate a Child's mental health condition. Services that sustain, support, improve, or make more tolerable a mental health condition are considered to ameliorate the condition and are thus covered as EPSDT services.

f) Members less than 21 years of age may receive up to five Family Therapy sessions before a mental health diagnosis is required. Contractor must provide Family Therapy without regard to the five-visit limitation for Members less than 21 years of age with risk factors for mental health disorders or parents/caregivers with related risk factors, including separation from a parent/caregiver due to incarceration, immigration, or death; foster care placement; food insecurity;

housing instability; exposure to domestic violence or trauma; maltreatment; severe/ persistent bullying; and discrimination.

5) Billing and Claims

a) Dyadic Services Providers must be reimbursed in accordance with their Network Provider contract.

b) Contractor must not require Prior Authorization for Dyadic Services.

c) Contractor must not establish unreasonable or arbitrary barriers for accessing coverage.

d) Encounters for Dyadic Services must be submitted with allowable current procedural terminology codes as outlined in the Medi-Cal Provider Manual.

e) Multiple Dyadic Services are allowed on the same day and may be reimbursed at the FFS rate.

f) The DBH well-Child visit must be limited to those services that are not already covered in the medical well-Child visit, and any other service codes cannot be duplicative of services that have already provided in a medical well-Child visit or a DBH well-Child visit.

g) Dyadic caregiver service codes (screening, assessment, and brief intervention services provided to the parent or caregiver for the benefit of the Child) may be billed by either the medical well-Child Provider or the DBH well-Child visit Provider, but not by both Providers, when the dyad is seen on the same day by both Providers.

h) Tribal Health Programs, Rural Health Clinics (RHCs), and Federal Qualified Health Centers (FQHCs) are eligible to receive their All-Inclusive Rate from Contractor if Dyadic Services are provided by a billable Provider per APL 17-002 and APL 21-008.

i. Dyadic Services may be reimbursed at the FFS rate established for services, if the service provided does not meet the definition of a THP, RHC, or FQHC visit, or exceeds frequency limitations.

ii. THP, RHC, and FQHC Providers can bill FFS for Dyadic Services delivered in a clinical setting by Provider types named in the Non-Specialty Mental Health Services: Psychiatric and Psychological Services section of the Medi-Cal Provider Manual.

iii. THP, RHC, and FQHC Providers cannot double bill for Dyadic Services that are duplicative of other services provided through Medi-Cal.

iv. All Dyadic Services must be billed under the Medi-Cal identity of the Member less than 21 years of age.

L. Practice Guidelines

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

M. Asthma Preventive Services

Contractor must ensure availability of Asthma Preventive Services (APSs), including clinic-based and home-based asthma self-education, and in-home environmental trigger assessments for all Members with a diagnosis of asthma. APSs may be provided by a Physician or a Non-Physician Medical Practitioner, or a licensed practitioner of the healing arts within their scope of practice. APSs may also be provided by unlicensed Providers, which may include CHW, who have met the qualifications of an APS Provider and are providing these services under a supervising Physician or Non-Physician Medical Practitioner, clinic, hospital, local health jurisdiction, or community-based organization.

N. Community Health Workers Services

1) Contractor must ensure availability of CHW Services to all Members that meet the eligibility criteria in accordance with 42 CFR section 440.130(c).

2) Contractor must adhere to DHCS guidance on service definitions, eligible populations, and CHW Provider parameters as stated in APL 22-016.

a) CHW services are defined as preventive health services delivered by a CHW to prevent disease, disability, and other health conditions or their progression; to prolong life; and to promote physical and mental health. CHWs may include individuals known by a variety of job titles, such as promotores, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals, with the qualifications specified below.

b) CHW services are considered Medically Necessary for Members with one or more chronic health conditions (including Behavioral Health) or exposure to violence and trauma, who are at risk for a chronic health condition or environmental health exposure, who face barriers in meeting their health or health-related social needs, and/or who would benefit from preventive services.

3) CHW Provider and Supervising Provider Requirements

a) Contractor must determine, verify, and validate CHW Providers can provide CHW Services in an effective manner consistent with culturally and linguistically appropriate care.

b) CHW Providers must have lived experience that aligns with and provides a connection between CHW and the Member population being served in.

c) CHWs must have lived experience that aligns with and provides a connection between the CHW and the Member or population being served. This may include, but is not limited to, experience related to incarceration, military service, pregnancy and birth, disability, foster system placement, homelessness, mental health conditions or substance use, or being a survivor of domestic or intimate partner violence or abuse and exploitation. Lived experience may also include shared race, ethnicity, sexual orientation, gender identity, language, or cultural background with one or more linguistic, cultural, or other groups in the community for which the CHW is providing services.

d) Contractor must contract with a Supervising Provider to oversee CHW providers and the services delivered to Members. CHW providers can be supervised by a community-based organization (CBO) or a local health jurisdiction (LHJ) that does not have a licensed Provider on

staff in alignment with the Provider Manual and APL 22-016.

e) Contractor must ensure that Network Providers and Subcontractors contracting with or employing CHWs to provide Covered Services have adequate supervision and training.

f) Contractor must ensure CHW Providers demonstrate, and Supervisor Providers maintain evidence of, minimum qualifications through the CHW certificate pathway, Violence Prevention certificate pathway, or Work experience pathway.

g) Certificate Pathway: CHWs demonstrating qualifications through the Certificate Pathway must provide proof of completion of at least one of the following certificates: CHW Certificate: A valid certificate of completion of a curriculum that attests to demonstrated skills and/or practical training in the following areas: communication, interpersonal and relationship building, service coordination and navigation, capacity building, advocacy, education and facilitation, individual and community assessment, professional skills and conduct, outreach, evaluation and research, and basic knowledge in public health principles and Social Drivers of Health (SDOH), as determined by the Supervising Provider. Certificate programs must also include field experience as a requirement. A CHW Certificate allows a CHW to provide all covered CHW services described in APL 22-016, including violence prevention services.

h) Violence Prevention Professional Certificate: For individuals providing CHW violence prevention services only, a Violence Prevention Professional (VPP) Certificate issued by Health Alliance for Violence Intervention or a certificate of completion in gang intervention training from the Urban Peace Institute. A VPP Certificate allows a CHW to provide CHW violence prevention services only. A CHW providing services other than violence prevention services must demonstrate qualification through either the Work Experience Pathway or by completion of a General Certificate.

i) Work Experience Pathway: An individual who has at least 2,000 hours working as a CHW in paid or volunteer positions within the previous three years and has demonstrated skills and practical training in the areas described above, as

determined and validated by the Supervising Provider, may provide CHW services without a certificate of completion for a maximum period of 18 months. A CHW who does not have a certificate of completion must earn a certificate of completion, as described above, within 18 months of the first CHW visit provided to a Member.

j) Contractor must have a process for verifying qualifications and experience of Supervising Providers, which must extend to individuals employed by, or delivering CHW Services on behalf of, the Supervising Provider.

k) Contractor must ensure Supervising Providers and CHW Providers comply with all applicable State and federal laws and regulations, Contract requirements, and other DHCS guidance, including APLs and PLs.

O. Community Health Workers Provider Capacity

1) Contractor must ensure and monitor appropriate, adequate Networks within its Service Area, including for CHW Services as stated in APL 23-001.

2) Contractor must use data-driven approaches to determine and understand priority populations eligible for CHW Services, including but not limited to, using past and current Member utilization/encounters, frequent hospital admissions or emergency department visits, demographic and Social Drivers of Health data, referrals from the community, and needs assessments.

P. Identifying Members for Community Health Workers

1) Contractor must require a referral for CHW Services submitted by a Physician or other licensed practitioner of the healing arts within their scope of practice under State law.

2) Contractor must accept recommendations for CHW Services from other licensed practitioners, whether they are in the Network or out-of-Network Providers, within their scope of practice, including physician assistants, nurse practitioners, clinical nurse Specialists, podiatrists, nurse midwives, Licensed Midwives, registered nurses, public health nurses, psychologists, licensed marriage and family therapists, licensed clinical social workers, licensed professional clinical counselors, dentists, registered dental hygienists, licensed educational psychologists, licensed vocational nurses, and pharmacists.

Q. Cancer Biomarker Testing

Contractor must comply with APL 22-010 and cover Medically Necessary biomarker testing for Members with advanced or metastatic stage 3 or 4 cancer and cancer progression or recurrence in the Member with advanced or metastatic stage 3 or 4 cancer. Contract is prohibited from imposing Prior Authorization requirements on biomarker testing that is associated with a federal Food and Drug Administration (FDA)-approved therapy for advanced or metastatic stage 3 or 4 cancer.

5.3.8 Investigational Services

A. Contractor must cover investigational services as defined in 22 CCR section 51056.1(b) when a service is determined to be investigational pursuant to 22 CCR section 51056.1(c), and all requirements in 22 CCR section 51303(h) are met and documented in the Member's Medical Record.

B. Routine Patient Care Costs for Clinical Trials

1) Contractor must cover routine patient care costs for Members participating in a qualifying clinical trial including items and services furnished in connection with participation by Members in a qualifying clinical trial pursuant to 42 USC section 1396d(a)(30), and W&I section 14132.98. A qualifying clinical trial is a clinical trial in any clinical phase of development that is conducted in relation to the prevention, detection, or treatment of any serious or life-threatening disease or condition.

2) Routine patient care costs are costs associated with the provision of health care services, including drugs, items, devices, and services that would otherwise be covered under the Medi-Cal program if those drugs, items, devices, and services were not provided in connection with an approved clinical trial program.

3) Coverage of routine patient care costs must be provided regardless of geographic location or if the treating Provider or principal investigator of the qualifying clinical trial is a Network Provider.

4) Coverage of routine patient care costs must be based on Provider’s and principal investigator’s approval regarding the Member’s appropriateness for the qualifying clinical trial.

5) The coverage determination must be expedited and completed within 72 hours.

6) Contractor must require the submission of the “Medicaid Attestation Form on the Appropriateness of the Qualifying Clinical Trial” for approval of the clinical trial. The attestation form must include the following information:

   a) The Member’s name and client identification number;

   b) The national clinical trial number;

   c) A statement signed by the principal investigator attesting to the appropriateness of the qualified clinical trial; and

   d) A statement signed by the Provider attesting to the appropriateness of the qualified clinical trial.

Exhibit A, ATTACHMENT III

5.4 Community Based Adult Services

5.4.1 Covered Services
5.4.2 Coordination of Care
5.4.3 Required Reports for the Community Based Adult Services Program
5.4.4 Community Participation
5.4.5 Community Based Adult Services Program Integrity

5.4 Community Based Adult Services

5.4.1 Covered Services

In addition to Exhibit A, Attachment III, Section 5.3 (*Scope of Services*), Contractor must cover Community Based Adult Services (CBAS) in accordance with the California Advancing and Innovating Medi-Cal (CalAIM) 1115(a) Demonstration, Number 11-W-00193/9 Special Terms and Conditions (STCs), including Sections V.A.19 through 30 and Attachments H and S, or in accordance with any subsequent demonstration amendment or renewal or successive demonstration, waiver, or other Medicaid authority governing the provision of CBAS. Contractor must cover CBAS and ensure provision of the following services:

A. Arrange for the provision of CBAS to Members determined eligible to receive CBAS core services, and additional services as needed, in accordance with the CalAIM STCs Section V.A.20.a and b, Attachment H, and Exhibit A, Attachment III, Subsection 5.4.2.C. (*Coordination of Care*);

B. Consider a Member's relationship with a previous Provider of services similar to CBAS when referring a Member to a CBAS Provider;

C. Cover CBAS as a bundled service through a CBAS Provider or arrange for the provision of unbundled CBAS based on the assessed needs of Members eligible for CBAS if a certified CBAS Provider is not available or not contracted, or there is insufficient CBAS Provider capacity in the area, as required by Exhibit A, Attachment III, Subsection 5.2.8.J. (*Specific Requirements for Access to Programs and Covered Services*). Arranging for unbundled CBAS services includes authorizing Covered Services and coordinating with community resources to assist Members whose CBAS Providers have closed, and Members who have similar clinical conditions as CBAS Members, to remain in the community, in accordance with the following requirements listed below.

    1) Unbundled CBAS Covered Services are limited to the following:

        a) Professional Nursing Services;

        b) Nutrition;

        c) Physical Therapy;

        d) Occupational Therapy;

        e) Speech and Language Pathology Services;

f) Nonmedical Emergency Transportation (NEMT) and Non-Medical Transportation (NMT), only between the Member's home and the CBAS unbundled service Provider; and

g) Non-Specialty Mental Health Services (NSMHS) and Substance Use Disorder (SUD) services that are Covered Services;

2) Contractor must coordinate care for unbundled CBAS services that are not Covered Services based on the assessed needs of the Member eligible for CBAS, including:

a) Personal Care Services;

b) Social Services;

c) Physical and Occupational Maintenance Therapy;

d) Meals;

e) Specialty Mental Health Services (SMHS); and

f) SUD Services

D. Ensure that Member access to Medicare Providers or services is not impeded or delayed through Contractor's provision of CBAS; and

E. Ensure continuity of care, in accordance with Exhibit A, Attachment III, Section 4.3 (*Population Health Management and Coordination of Care*), when Members switch Medi-Cal managed care plans and/or transfer from one CBAS Provider to another.

F. Arrange for the provision of CBAS Emergency Remote Services (ERS), in response to a Member's needs, and in accordance with CalAIM STCs Section V.A.21 and All Plan Letter (APL) 22-020. CBAS ERS must be provided in alternative Service Locations and/or via Telehealth, including telephone or virtual video conferencing, as clinically appropriate.

1) The circumstances for ERS are time-limited and vary based on the unique and identified needs documented in the Member's Individualized Health and Support Plan (IHSP). Contractor must assess Members at least every three months for ERS as part of the reauthorization of the Member's Individual Plan of Care (IPC) and review for continued need for ERS.

2) Telehealth delivery of ERS must meet the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements, and the methodology must be approved by Contractor. Contractor must demonstrate compliance with the Electronic Visit Verification (EVV) System requirements for personal care services and home health services in accordance with section 12006 of the 21st Century CURES Act and APL 22-014.

3) Contractor must provide ERS under the following circumstances:

a) State or local emergencies as determined by DHCS or Contractor, such as wildfires and power outages, to allow for the provision of ERS prior or subsequent to an official public health emergency declaration as determined by DHCS or Contractor; and

b) Personal emergencies, such as time-limited illness or injury, crises, or care transitions that temporarily prevent or restrict Members enrolled in CBAS from receiving CBAS in-person at the CBAS Provider location, subject to approval by Contractor.

5.4.2 Coordination of Care

A. Contractor must provide continuity of care to Members through continued access to a CBAS Provider with whom there is an existing relationship for up to 12 months after Member Enrollment. This requirement includes out-of-Network Providers if there are no Quality of Care issues and the Provider will accept Contractor's rate or the Medi-Cal Fee-For-Service (FFS) rate, whichever is higher, as set forth in Exhibit A, Attachment III, Subsection 5.2.12 (*Continuity of Care for Seniors and Persons with Disabilities*).

B. Contractor must ensure that CBAS IPCs are consistent with the Members' overall care plans and goals, based on Person-Centered Planning and completed in accordance with the CalAIM STCs Section V.A.20., "Individual Plan of Care".

C. Contractor must conduct the initial assessment and subsequent reassessments for Members requesting CBAS in accordance with the CalAIM STCs, Sections VIII.A.19.e and 23.b. In addition, Contractor must:

1) Within 30 calendar days from the initial eligibility inquiry request, Contractor must conduct the CBAS eligibility determination using a DHCS-approved assessment tool. CBAS eligibility determinations must include a face-to-face review with the Member by a

Registered Nurse with level of care determination experience for Members who have not previously received CBAS through Contractor's Medi-Cal Managed Care Health Plan. Contractor may forgo a face-to-face review if Contractor determined that the Member is clinically eligible for CBAS and needs an expedited start date;

2) Develop and implement an expedited assessment process to determine CBAS eligibility within 72 hours of receipt of a CBAS authorization request for a Member in a hospital or Skilled Nursing Facility (SNF) whose discharge plan includes CBAS, or who is at high risk of admission to a hospital or SNF or faces an imminent and serious threat to their health;

3) Conduct a reassessment, with family involvement, when appropriate, and redetermination of the Member's eligibility for CBAS at least every six months after the initial assessment or up to every 12 months when determined by Contractor to be clinically appropriate. When a Member requests that services remain at the same level or requests an increase in services due to a change in their level of need, contractor may conduct the reassessment using only the Member's CBAS IPC, including any supporting documentation supplied by the CBAS Provider;

4) Notify Members in writing of their CBAS assessment determination in accordance with the timeframes identified in the CalAIM STCs, Section VIII.A.23.b.i. Contractor's written notice must be approved by DHCS and include procedures for Grievances and Appeals in accordance with current requirements identified in Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*);

5) Require that CBAS Providers update a Member's CBAS Discharge Plan of Care and provide a copy to the Member and to Contractor whenever a Member's CBAS services are terminated. The CBAS Discharge Plan of Care must include:

   a) The Member's name and ID number;

   b) The name(s) of the Member's Physician(s);

   c) If applicable, the date the Notice of Action denying authorization for CBAS was issued;

   d) If applicable, the date the CBAS benefit will be terminated;

e) Specific information about the Member's current medical condition, treatments, and medications;

f) Potential referrals for Medically Necessary services and other services or community resources that the Member may need upon discharge;

g) Contact information for the Member's Case Manager; and

h) A space for the Member or the Member's representative to sign and date the Discharge Plan of Care.

D. Contractor must coordinate with the CBAS Provider to ensure the following:

1) CBAS IPCs are consistent with Members' overall care plans and goals developed by Contractor;

2) Timely exchange of the following coordination of care information: Member Discharge Plan of Care, reports of incidents that threaten the welfare, health and safety of the Member, and Significant Changes in the Member's condition;

3) Clear communication pathways between the appropriate CBAS Provider staff and Contractor staff responsible for CBAS eligibility determinations, service authorizations, and care planning, including identification of the lead care coordinator for Members who have a care team and Utilization Management; and

4) The CBAS Provider receives advance written notification and training prior to any substantive changes in Contractor's policies and procedures related to CBAS.

E. In addition to the requirements for unbundled CBAS contained in Exhibit A, Attachment III, Subsection 5.4.1 (*Covered Services*), and in accordance with Exhibit A, Attachment III, Subsection 5.4.2 (*Coordination of Care*), Contractor must coordinate care for unbundled CBAS that are not Covered Services, based on the assessed needs of the Member eligible for CBAS, including:

1) Personal Care Services

2) Social Services

3) Physical and Occupational Maintenance Therapy

4) Meals

5) SMHS

6) SUD services that are not Covered Services.

5.4.3 Required Reports for the Community Based Adult Services Program

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

A. How many Members have been assessed for CBAS and the total number of Members currently receiving CBAS, either as a bundled or unbundled service, on a quarterly basis;

B. Identification of CBAS Providers added to or deleted from Contractor's Network, and when there is a 5% drop in capacity, in the quarterly Network changes submission required in Exhibit A, Attachment III, Subsection 5.2.13.C. (*Network Reports*);

C. A summary of any complaints surrounding the provision of CBAS; and

D. Reports on the following areas:

1) Appeals related to requesting CBAS and the inability to receive those services or receiving more limited services than requested;

2) Appeals related to requesting a particular CBAS Provider and the inability to access that Provider;

3) Excessive travel times to access CBAS;

4) Grievances regarding CBAS Providers;

5) Grievances regarding Contractor assessment and/or reassessment; and

6) Any reports pertaining to the health and welfare of Members utilizing CBAS.

E. On an annual basis, Contractor must provide a list of its contracted CBAS Providers and its CBAS accessibility standards.

5.4.4 Community Participation

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

5.4.5 Community Based Adult Services Program Integrity

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

Exhibit A, ATTACHMENT III

5.5 Mental Health and Substance Use Disorder Benefits

5.5.1 Mental Health Parity Requirements
5.5.2 Non-Specialty Mental Health Services and Substance Use Disorder Services
5.5.3 Non-Specialty Mental Health Services Providers
5.5.4 Emergency Mental Health and Substance Use Disorder Services
5.5.5 Mental Health and Substance Use Disorder Services Disputes
5.5.6 No Wrong Door for Mental Health Services

5.5 Mental Health and Substance Use Disorder Benefits

5.5.1 Mental Health Parity Requirements

Contractor must comply with all mental health parity requirements in 42 Code of Federal Regulations (CFR) section 438.900 *et seq*. Contractor must ensure it is not applying any financial or treatment limitation to mental health or Substance Use Disorder (SUD) benefits in any classification that is more restrictive than the predominant financial or treatment limitation applied to medical and surgical benefits in the same classification.

5.5.2 Non-Specialty Mental Health Services and Substance Use Disorder Services

A. Non-Specialty Mental Health Services (NSMHS) set forth in Welfare and Institutions Code (W&I) section 14189 are Covered Services in accordance with W&I section 14184.402, unless otherwise specifically excluded under the terms of this Contract. Contractor must consider equity in the provision of such services.

B. Contractor must cover NSMHS including: individual and group mental health evaluation and treatment, including psychotherapy, Family Therapy, and Dyadic Services; psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition; outpatient services for the purposes of monitoring drug therapy; psychiatric consultation; and outpatient laboratory, drugs, supplies, and supplements. Contractor must cover hypnotherapy, health behavior assessments and interventions, psychiatric collaborative care, and other NSMHS services described in the Medi-Cal Provider Manual as mental health evaluation and treatment NSMHS. Contractor must cover mental health screening services described in the Medi-Cal Provider Manual as NSMHS, including but not limited to adverse childhood experiences (ACE) screening, brief emotional/behavioral assessments, depression screening, general developmental screening, autism spectrum disorder screening, and other screening services in accordance with Exhibit A, Attachment III, Subsection 5.5.2.F. (*Non-Specialty Mental Health Services and Substance Use Disorder Services*). Contractor must cover SUD services including: drug and alcohol Screening, Assessment, Brief Intervention and Referral to Treatment (SABIRT) services; tobacco cessation counseling; medications for addiction treatment (also known as medication-assisted treatment or MAT) when delivered in Primary Care offices, emergency departments, inpatient hospitals, and other contracted medical settings; and Medically Necessary Behavioral Health Services. Covered NSMHS and SUD Services can be delivered in person and via Telehealth/telephone as specified in Exhibit A, Attachment III, Subsection 5.3.1 (*Covered Services*).

C. If a Member is receiving NSMHS and is determined to meet the criteria for Specialty Mental Health Services (SMHS) as defined by W&I section 14184.402, Contractor must use DHCS-approved standardized transition tools in accordance with Exhibit A, Attachment III, Subsection 5.5.2.K. (*Non-Specialty Mental Health Services and Substance Use Disorder Services*) as required when Members who have established relationships with contracted mental health Providers experience a change in condition requiring SMHS. Likewise, if a Member is receiving SMHS and is determined to meet the criteria for NSMHS as defined by W&I section 14184.402, Contractor must use DHCS-approved standardized transition tools in accordance with Exhibit A, Attachment III, Subsection 5.5.2.K. (*Non-Specialty Mental Health Services and Substance Use Disorder Services*) as required when Members who have established relationships with SMHS Providers experience a change in condition requiring NSMHS. Contractor must continue to cover the provision of NSMHS provided to a Member concurrently receiving SMHS when those services are not duplicative and provide coordination of care with the County Mental Health Plan (MHP) in accordance with Exhibit A, Attachment III, Subsection 5.5.2.K. (*Non-Specialty Mental Health Services and Substance Use Disorder Services*). This provision does not preclude coverage of Behavioral Health Services that are within the scope of practice of licensed mental health care Primary Care Providers (PCPs) and mental health care Providers in accordance with All Plan Letter (APL) 26-002 and APL15-008.

D. For Members ages 21 and over who meet the criteria for NSMHS set forth in the W&I section 14184.402(b)(2), Contractor must cover NSMHS that are Medically Necessary Covered Services in accordance with W&I section 14059.5. For Members ages 21 and over, Contractor must cover SUD services that are Medically Necessary Covered Services in accordance with W&I section 14059.5. Contractor's coverage of NSMHS and SUD services must comply with W&I section 14184.402(f).

E. For Members less than 21 years of age, Contractor must cover NSMHS that are Medically Necessary Covered Services in accordance with W&I section 14184.402(b)(2). For Members less than 21 years of age, Contractor must cover SUD services that are Medically Necessary Covered Services. Medical Necessity determinations for NSMHS and SUD services must be made pursuant to W&I section 14059.5, and as required pursuant to 42 United States Code (USC) section 1396dI. For Members less than 21 years of age, NSMHS and Covered SUD services are Medically Necessary if they are necessary to correct or ameliorate a mental health or substance use condition discovered by an Early Periodic Screening, Diagnosis and Testing (EPSDT) screening. NSMHS and SUD services need not be curative or restorative to ameliorate a mental health

or substance use condition. NSMHS and SUD services that sustain, support, improve, or make more tolerable a mental health or substance use condition are considered to ameliorate the mental health or substance use condition, and Contractor must cover them. Contractor's coverage of NSMHS and SUD services must comply with W&I section 14184.402(f).

F. Contractor must cover mental health and SUD screening, including, but not limited to, tobacco, alcohol and illicit drug screening, in accordance with American Academy of Pediatrics (AAP) Bright Futures Periodicity Schedule and United States Preventive Services Taskforce (USPSTF) grade A and B recommendations for adults; ACE screening; brief emotional/behavioral assessments; depression screening; general developmental screening; autism spectrum disorder screening; and SABIRT Services. Contractor must develop and implement policies and procedures for mental health and substance use screenings and services provided by a PCP, including, but not limited to, provision of SABIRT Services, and referrals for additional assessments and treatments as indicated by the discovery of condition or potential conditions from screening services, as required by Exhibit A, Attachment III, Subsections 4.3.12 (*Mental Health Services*) and 4.3.13 (*Alcohol and Substance Use Disorder Treatment Services*).

G. Contractor must cover a mental health assessment without requiring Prior Authorization. Contractor must follow the authorization criteria requirements outlined in Exhibit A, Attachment III, Section 2.3 (*Utilization Management Program*) of this Contract for authorizing additional mental health and SUD services. Consistent with the No Wrong Door policies set forth in W&I section 14184.402, Contractor must cover the assessment and any NSMHS provided during the assessment period for any Member seeking care, even prior to the determination of a diagnosis, even prior to the determination of whether NSMHS criteria set forth in W&I section 14184.402(b)(2) are met, and even if the Member is later determined to need SMHS and/or SUD services and is referred to the MHP or to the County Department responsible for SUD treatment. Contractor must cover NSMHS even if the service was not included in the individual treatment plan, and even if the Member has a co-occurring mental health condition and SUD.

H. Contractor must develop and implement policies and procedures for tracking mental and Behavioral Health screenings, assessments, and treatment services provided by licensed mental health care Providers.

I. Contractor must cover and pay for all mental health and SUD services that are Medically Necessary Covered Services for the Member, including the following:

1) Emergency room professional services as described in 22 CCR section 53855 including all professional physical, mental, and substance use treatment services, including screening examinations necessary to determine the presence or absence of an Emergency Medical Condition and, if an Emergency Medical Condition exists, for all services Medically Necessary to stabilize the Member;

2) Facility charges claimed by emergency departments per APL 22-005 and Behavioral Health Information Notice (BHIN) 22-011;

3) All laboratory and radiology services necessary for the diagnosis, monitoring, or treatment of a Member's mental health condition;

4) Non-Medical Transportation (NMT) services required by Members to access Medi-Cal covered mental health services and SUD services, in compliance with APL 22-008 and this Contract. These services include, but are not limited to, SMHS, Drug Medi-Cal (DMC) services, and Drug Medi-Cal Organized Delivery System (DMC-ODS) services;

5) NMT services and, for Members less than 21 years of age, Non-Emergency Medical Transportation (NEMT) services, to and from DMC services, DMC-ODS services, and SMHS, in compliance with APL 22-008 and this Contract;

6) Medically Necessary Covered Services after Contractor has been notified by a DMC, DMC-ODS, County Mental Health Plan (MHP), or mental health Provider that a Member has been admitted to an inpatient psychiatric facility, including an Institution for Mental Diseases (IMD) as defined by 9 CCR section 1810.222.1, regardless of the age of the Member. These services include, but are not limited to:

    a) The initial health history and physical examination required upon admission, consultations, and any Medically Necessary Covered Services; Skilled Nursing Facility (SNF) room and board when psychiatric nursing facility services are provided to Members age 65 and over.

    b) Contractor must not cover other inpatient psychiatric facility room and board charges or other services that are reimbursed as part of the inpatient psychiatric facility per diem rate.

7) All Medically Necessary Medi-Cal covered psychotherapeutic drugs, when administered in the outpatient setting as part of medical services for Members not otherwise excluded under this Contract. This includes reimbursement for Medically Necessary Medi-Cal covered psychotherapeutic drugs administered by out-of-Network Providers for Members not otherwise excluded under this Contract;

8) Reimbursement to pharmacies for psychotherapeutic drugs must be provided through the Medi-Cal Fee-For-Service (FFS) program. To qualify for reimbursement under this provision, a pharmacy must be enrolled as a Medi-Cal Provider in the Medi-Cal FFS program;

9) Contractor must not materially delay access to Covered Services per Paragraphs 3), 4), and 5) above through the application of Utilization Review controls, such as Prior Authorization, or by requiring that Covered Services be provided through Contractor's Network, consistent with Contractor's obligation to provide timely Covered Services under this contract.

J. Contractor must use DHCS-approved standardized screening tools (including standardized screening tools specific for adults and standardized screening tools specific for Children and youth) to ensure Members seeking mental health services who are not currently receiving covered NSMHS or SMHS are referred to the appropriate delivery system for mental health services, either in Contractor's Network or the MHP's network, in accordance with the No Wrong Door policies set forth in W&I section 14184.402(h) and specified in Exhibit A, Attachment III, Subsection 4.3.12 (*Mental Health Services*).

K. If a Member becomes eligible for SMHS while receiving covered NSMHS, Contractor must continue the provision of non-duplicative, Medically Necessary NSMHS even if the Member is simultaneously accessing SMHS.

1) Contractor must enter into a MOU with the MHP in accordance with Exhibit A, Attachment III, Section 5.6 (*MOUs with Local Government Agencies, County Programs, and Third Parties*) to ensure Medically Necessary NSMHS and SMHS provided concurrently are coordinated and non-duplicative.

2) Contractor must develop and implement written policies and procedures to ensure that Members meeting criteria for SMHS and as indicated by a DHCS-approved standardized transition tools (including standardized transition tools specific for adults and standardized transition tools specific for Children and youth) are

referred to the MHP in accordance with Exhibit A, Attachment III, Subsection 4.3.12 *(Mental Health Services*). Likewise, Contractor must develop and implement written policies and procedures to ensure that Members meeting criteria for NSMHS and as indicated by a DHCS-approved standardized transition tools (including standardized transition tools specific for adults and standardized transition tools specific for Children and youth) are referred by the MHP to Contractor in accordance with Exhibit A, Attachment III, Subsection 4.3.12 *(Mental Health Services*).

L. Contractor must make best efforts to ensure that a Member's existing mental health Provider is notified during an Urgent Care situation, when possible. Contractor must allow the Member's existing mental health Provider to coordinate care with the MHP or emergency room personnel for Urgent Care.

M. Contractor must develop and implement policies and procedures for the provision of psychiatric emergencies during non-business hours.

N. Contractor must monitor and track utilization data for NSMHS as specified in Exhibit A, Attachment III, Subsection 2.3.3 (*Review of Utilization Data*).

5.5.3 Non-Specialty Mental Health Services Providers

A. In addition to Exhibit A, Attachment III, Subsection 5.2.1 (*Access to Network Providers and Covered Services*), Contractor must increase the number of NSMHS Providers within its Network as necessary to accommodate anticipated Enrollment growth, which DHCS will evaluate through the Network certification. Contractor may contract with any mental health care Provider to provide services within their scope of practice. The number of NSMHS Providers available must be sufficient to meet referral and appointment access standards for routine care and must meet the Timely Access Regulation per Health and Safety Code (H&S) section 1367.03, and 28 CCR section 1300.67.2.2, in accordance with the requirements set forth in Exhibit A, Attachment III, Subsection 5.2.3.D (*Network Composition*). Contractor's NSMHS Providers must support current and desired service utilization trends for its Members.

1) Contractor must authorize and arrange for out-of-Network Providers when the provider type is unavailable within time or distance standards. Authorization of out-of-Network Providers in Contractor's Service Area(s) must be prioritized over authorization of out-of-Network Providers in adjoining Service Area(s), unless an out-of-Network Provider in an adjoining Service Area(s) is more conveniently located for a Member or meets time or distance standards.

2) Contractor may contract with a MHP to ensure access to NSMHS.

Contractor must develop and implement policies and procedures for the secure exchange of Member Information with the MHP to facilitate referrals and Care Coordination. The policies and procedures must cover:

a) Sharing Protected Health Information (PHI) with the MHP for SMHS and the County Department responsible for SUD treatment, including when required by law, obtaining Member authorization to release information that allows the exchange of treatment history, active treatment, and health information;

b) Data sharing agreements with the MHP for SMHS and the County Department responsible for SUD treatment and, when required by law, a Business Associate Agreement that addresses the sharing of information related to mental health services and SABIRT services; and

c) Collecting and reporting data on Members receiving Medi-Cal NSMHS to the MHP.

B. Notwithstanding Exhibit A, Attachment III, Subsection 2.2.13 (*Credentialing and Recredentialing*), if a NSMHS Provider is accredited by the National Committee for Quality Assurance (NCQA), Contractor may deem the Provider credentialed or re-credentialed. Additionally, Contractor must develop and maintain policies and procedures that ensure that the credentials of licensed NSMHS Providers have been verified in accordance with 42 CFR section 438.214 and APL 22-013.

C. Any time that a Member requires a Medically Necessary NSMHS that is not available within the Network, Contractor must ensure timely access to out-of-Network Providers and Telehealth Providers, in accordance with H&S section 1367.03 and 28 CCR section 1300.67.2, as necessary to meet NSMHS access requirements.

5.5.4 Emergency Mental Health and Substance Use Disorder Services

In addition to the requirements set forth in Exhibit A, Attachment III, Section 5.6 (*MOUs with Local Government Agencies, County Programs, and Third Parties*), Contractor must have a MOU with the MHP to refer Members in need of Urgent Care and Emergency Services, including person-to-person telephone transfers, to the county crisis program during their call center hours. The MOU must be executed in accordance with the requirements specified in Exhibit A, Attachment

III, Sections 4.3 (*Population Health Management and Coordination of Care*) and 5.3 (*Scope of Services*).

5.5.5 Mental Health and Substance Use Disorder Services Disputes

If Contractor and an MHP cannot agree on the appropriate place of care, disputes must be resolved pursuant to APL 21-013.

A. Contractor must enter an MOU with the MHP in accordance with Exhibit A, Attachment III, Subsection 5.6.1 (*MOU Purpose*) to include a process for resolving disputes between Contractor and the MHP that includes a means for Members to receive Medically Necessary services, including NSMHS, while the dispute is being resolved.

B. Pursuant to 9 CCR section 1850.525, Contractor must not delay the provision of Medically Necessary services during the resolution of a dispute between Contractor and MHP. Contractor must comply with the rules set forth in 9 CCR section 1850.525 for determining the responsibility for managing ongoing care and financial responsibility for services provided to Members during the dispute period. When disputes concern Contractor's contention that the MHP is required to deliver SMHS to a Member either because the Member's condition would not be responsive to physical health care based treatment or because the MHP has incorrectly determined that the Member's does not meet SMHS criteria, Contractor must manage the care of the Member in accordance with 9 CCR section 1850.525 and APL 21-013 until the dispute is resolved.

C. Contractor must provide case management and Care Coordination for all Medically Necessary services, including those services that are the subject of a dispute between Contractor and an MHP.

D. Regardless of MOU status, Contractor and the MHP must adhere to the routine dispute resolution process and expedited dispute resolution process requirements set forth in APL 21-013.

E. If DHCS renders a decision for the dispute that includes a finding that Contractor is financially liable to the MHP for services, Contractor must comply with the requirements in 9 CCR section 1850.530. If necessary, DHCS will enforce the decision, including withholding funds to meet any financial liability.

F. Contractor must monitor and track the number of disputes with MHPs. Upon request, Contractor must report all disputes to DHCS.

5.5.6 No Wrong Door for Mental Health Services

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

A. Contractor must provide or arrange for the provision of the following NSMHS:

1) Mental health evaluation and treatment, including individual, group, and family psychotherapy.

2) Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition.

3) Outpatient services for purposes of monitoring drug therapy.

4) Psychiatric consultation, excluding separately billable psychiatric drugs claimed by outpatient pharmacy Providers via Medi-Cal Rx.

5) Outpatient laboratory, drugs, supplies, and supplements.

B. Contractor must provide or arrange for the provision of the NSMHS listed above for the following populations after screening:

1) Members ages 21 and over with mild to moderate distress, or mild to moderate impairment of mental, emotional, or behavioral functioning resulting from mental health disorders, as defined by the current Diagnostic and Statistical Manual of Mental Disorders;

2) Members who are less than 21 years of age, to the extent that they are eligible for services through the EPSDT benefit as described in Exhibit A, Attachment III, Subsection 5.3.4.E (*EPSDT Services*) of this Contract, regardless of the level of distress or impairment, or the presence of a diagnosis; and,

3) Members of any age with potential mental health disorders not yet diagnosed.

C. Contractor must cover and pay for emergency room professional services as described in 22 CCR Section 53855.

D. In accordance with APL 21-014, Contractor must, in a Primary Care setting, provide covered SUD services, including alcohol and drug screening, assessments, brief interventions, and referral to treatment for Members aged 11 years old and older, including Members who are pregnant. Contractor must also provide or arrange for the provision of:

1) Medications for Addiction Treatment (MAT), also known as medication-assisted treatment, provided in Primary Care, inpatient hospital, emergency departments, and other contracted medical settings; and

2) Emergency Services necessary to stabilize the Member.

E. Contractor must implement standardized Screening and Transition of Care Tools for Medi-Cal Mental Health Services in accordance with APL 22-005 and APL 25-010. Contractor must update and align policies and procedures and MOUs with mental health plans to ensure compliance and communicate updates to Providers as necessary.

1) In accordance with APL 22-005, Members ages 21 and over must be screened using the Adult Screening Tool and transitioned using the Adult Transition of Care Tool.

2) In accordance with APL 22-005, Members less than 21 years of age must be screened using the Youth Screening Tool and transitioned using the Youth Transition of Care Tool.

F. Consistent with W&I section 14184.402(f) and APL 22-005, Contractor must cover clinically appropriate and covered NSMHS prevention, screening, assessment, and treatment services even when:

1) Services are provided prior to determination of a diagnosis, during the assessment period, or prior to a determination of whether NSMHS or SMHS access criteria are met;

2) Services are not included in an individual treatment plan;

3) The Member has a co-occurring mental health condition and SUD; or

4) NSMHS and SMHS are provided concurrently, if those services are coordinated and not duplicated.

Exhibit A, ATTACHMENT III

5.6 MOUs with Local Government Agencies, County Programs, and Third Parties

5.6.1 MOU Purpose
5.6.2 MOU Requirements
5.6.3 MOU Oversight and Compliance

5.6 MOUs with Local Government Agencies, County Programs, and Third Parties

Memorandum of Understandings (MOUs) entered into pursuant to this Contract and as set forth in All Plan Letters (APLs) are binding, contractual agreements between Contractor and third parties that set forth the responsibilities and obligations of Contractor and a third party, including Local Government Agencies, county programs, and third-party entities, to coordinate and facilitate the provision of Medically Necessary services to Members, sharing data, and as applicable, avoiding the duplication of services where Members are served by multiple parties.

5.6.1 MOU Purpose

Contractor must coordinate with Local Government Agencies (LGAs), county programs, and third-party entities to ensure that Members receive all Medically Necessary services even if those services are not the financial responsibility of Contractor. In circumstances where Contractor is coordinating care and not financially responsible for the care, Contractor must negotiate in good faith and execute a MOU, incorporating all required provisions of this Contract, APLs, and MOU templates and guidance, with the following Local Government Agencies, county program and third-party entities and county programs to ensure Care Coordination, data sharing, and non-duplicative services for Members. Contractor and the LGAs, county programs, and third-party entities may incorporate requirements in addition to any requirements set forth in this Contract or any DHCS issued templates so long as such requirements do not conflict with any required provision. Contractor must use good-faith efforts to consult with persons who have direct experience with Members receiving services from the below programs in the development of the MOU.

A. Contractor must execute MOUs with Local Health Departments (LHDs) in each county within Contractor's Service Area for the following programs and services, at a minimum:

   1) California Children's Services (CCS);

   2) Maternal and Child Health (MCH);

   3) Tuberculosis (TB) Direct Observed Therapy (DOT);

   4) For Community Health Worker (CHW) services, as appropriate; and

   5) All other Medically Necessary services that are the responsibility of LHDs, not otherwise specified.

B. Contractor must execute MOUs with Women, Infants, & Children (WIC) agencies in each county within Contractor's Service Area.

C. Contractor must execute MOUs with LGAs, such as the County Behavioral Health Department and County Social Services Department, in each county within Contractor's Service Area to assist with coordinating the following programs and services, at a minimum:

1) Specialty Mental Health Services (SMHS);

2) Alcohol and Substance Use Disorder (SUD) treatment services including counties participating in the Drug Medi-Cal Organized Delivery System (DMC-ODS); 3) In-Home Supportive Services (IHSS).

D. Contractor must execute MOUs to coordinate programs and services for Members with the following LGAs in each county within Contractor's Service Area, at a minimum:

1) Social services; and

2) Child welfare departments.

E. Contractor must execute MOUs to coordinate services provided by Regional Centers (RCs) for persons with Developmental Disabilities in accordance with APLs relevant to MOUs, including DHCS issued templates.

F. By July 1, 2024 (or such later date determined by DHCS), Contractor must execute MOUs with LGAs in each county within Contractor's Service Area to assist with coordinating, at a minimum, Targeted Case Management (TCM).

G. By January 1, 2025 (or such later date determined by DHCS), Contractor must execute MOUs to coordinate programs and services for Members with First 5 County Commissions in each county within Contractor's Service Area.

H. By January 1, 2027 (or such later date determined by DHCS) Contractor must collaborate with and execute MOUs with Local Education Agencies (LEAs) in each county within Contractor's Service Area to ensure that Members' Primary Care Provider (PCP) cooperates and collaborates in the development of Individual Education Plans (IEP) or Individual Family Service Plans (IFSP) as required in Exhibit A, Attachment III, Subsection 4.3.16 (*School-Based Services*).

I. By January 1, 2026, Contractor must collaborate and execute MOUs with California Department of Corrections and Rehabilitation, county jails, and Youth Correctional Facilities that go live with pre-release services prior to, or on January 1, 2026. For Correctional Facilities that go live after January 1, 2026, Contractor must collaborate and execute MOUs with California Department of Corrections and Rehabilitation, county jails, and Youth Correctional Facilities by the Correctional Facilities' go live date.

5.6.2 MOU Requirements

A. MOUs must contain all the following components, at a minimum:

1) Identification of services that are the responsibilities of each party under the MOU and the populations that are to be served;

2) Identification of the oversight responsibilities of each party, including the designation of a responsible person and liaison by each party, and notification to the other party of changes to the responsible person and liaison;

3) Establishment of policies and procedures for eligibility, screening, assessment, evaluation, Medical Necessity determination, and referral systems;

4) Establishment of policies and procedures for coordinating Member care between the parties, including but not limited to, referrals to applicable Enhanced Care Management (ECM), Community Supports and/or community-based resources;

5) Establishment of policies and procedures for the timely and frequent exchange of Member Information and data, including Behavioral Health and physical health data, maintaining the confidentiality of exchanged information and data, and obtaining Member consent;

6) Establishment of policies and procedures to address and document Quality Improvement (QI) activities for services covered under the MOU, including but not limited to, any applicable performance measures and QI initiatives, reports that track cross-system referrals, Member engagement, and service utilization;

7) Contractor must post on its website the date and time the quarterly meeting occurred, and, as applicable, distribute to meeting participants a summary of any follow-up action items, changes to

processes, or Corrective Actions that are necessary to fulfill obligations under this Contract and MOU.

8) Contractor must invite other party's executives to participate in quarterly meetings to facilitate appropriate committee representation, including local presence, to discuss and address Care Coordination and MOU-related issues.

9) Agreement by both parties, to the extent such non-Contractor party will agree to participate in quarterly meetings to discuss Care Coordination as well as systemic and case-specific concerns including allowing Subcontractors and Downstream Subcontractors to participate, as appropriate;

10) Establishment of policies and procedures detailing how complaints can be raised and how to resolve disputes between the parties, including but not limited to, a mutually agreed upon review process to facilitate timely resolution of disputes, differences of opinion and responsible entity for covering services until the dispute is resolved. The review process must not result in delays in Member access to services pending formal dispute resolution;

11) Establishment of policies and procedures regarding Member access to Medically Necessary services and Network Providers during non-business hours;

12) Policies and procedures for Member, Subcontractor, Downstream Subcontractor, and Network Provider education related to access to services covered under the MOU; and

13) Establishment of policies and procedures to address emergency preparedness protocols in accordance with Exhibit A, Attachment III, Article 6.0 (*Emergency Preparedness and Response*).

B. In addition to the MOU requirements listed in Paragraph A of this Subsection, MOUs must contain the following components identified in this Paragraph B, as applicable:

1) MOUs with County Mental Health Plans (MHPs)

a) The requirements contained in Welfare and Institutions Code (W&I) section 14715;

b) Policies and procedures for the delivery of SMHS, including the MHP's provision of clinical consultation with Contractor for Members being treated for mental illness;

c) Policies and procedures for the delivery of Medically Necessary Non-Specialty Mental Health Services (NSMHS) within the PCP's scope of practice;

d) Policies and procedures for the timely and frequent exchange of Member information and data, including, as applicable, Behavioral Health and physical health data, maintaining the confidentiality of exchanged information and data, and, if necessary, obtaining Member consent;

e) Policies and procedures for the delivery of Medically Necessary Covered Services to Members who require SMHS, including but not limited to:

i. Prescription Drugs when administered in an outpatient setting and not otherwise excluded under this Contract;

ii. Laboratory, radiological and radioisotope services;

iii. Emergency room facility charges and professional services;

iv. Transportation;

v. Home health services;

vi. Drug Medi-Cal; and

vii. Medically Necessary Covered Services for Members who are patients in psychiatric inpatient hospitals or IMDs.

f) A provision that states any decision rendered by DHCS regarding a dispute between Contractor and the MHP concerning provision of Covered Services is not subject to the dispute procedures specified in Exhibit E, Section 1.21 (*Contractor's Dispute Resolution Requirements*);

g) Policies and procedures to ensure Medically Necessary NSMHS and SMHS provided concurrently are coordinated and non-duplicative; and

h) Policies and procedures to ensure that Members meeting criteria for SMHS and as indicated by a DHCS-approved

standardized transition tools (including standardized transition tools specific for adults and standardized transition tools specific for Children and youth) are referred to the MHP in accordance with Exhibit A, Attachment III, Subsection 4.3.12 *(Mental Health Services*) and Exhibit A, Attachment III, Subsection 5.5.2 (*Non-Specialty Mental Health Services and Substance Use Disorder Services*). Likewise, policies and procedures to ensure that Members meeting criteria for NSMHS and as indicated by a DHCS-approved standardized transition tools (including standardized transition tools specific for adults and standardized transition tools specific for Children and youth) are referred by the MHP to Contractor in accordance with Exhibit A, Attachment III, Subsection 4.3.12 *(Mental Health Services*) and Exhibit A, Attachment III, Subsection 5.5.2 (*Non-Specialty Mental Health Services and Substance Use Disorder Services*).

i) Contractor must report to DHCS updates from quarterly meetings in a manner and frequency specified by DHCS.

C. If Contractor reimburses the third-party entities or LGAs listed in Exhibit A, Attachment III, Subsection 5.6.1 (*MOU Purpose*) for services rendered, Contractor must execute a Network Provider Agreement, Subcontractor Agreement, and/or Downstream Subcontractor Agreement, as appropriate, in accordance with Exhibit A, Attachment III, Section 3.1 (*Network Provider Agreements, Subcontractor Agreements, Downstream Subcontractor Agreements, and Contractor's Oversight Duties*).

D. Executed MOUs must be publicly posted.

E. MOUs must not be delegated, except that Contractor may delegate its obligations under the MOU to a Fully Delegated Subcontractor or Partially Delegated Subcontractor, provided that such Fully Delegated Subcontractor or Partially Delegated Subcontractor is made a party to the MOU.

5.6.3 MOU Oversight and Compliance

A. MOU Oversight Requirements

Contractor must have processes in place to maintain collaboration among the parties to the MOU and identify strategies to monitor and assess the effectiveness of MOUs as follows:

1) Conduct regular meetings, which include the designated individuals responsible for oversight and performance under the MOU, at least

quarterly to address policy and practical concerns that may arise between MOU parties;

2) Resolve conflicts between MOU parties within a reasonable timeframe;

3) Designate a contact person to be responsible for the oversight and supervision of the terms of any MOUs and notify DHCS within five Working Days of any change to Contractor's liaison or responsible person as listed in the MOU;

4) Ensure Subcontractors, Downstream Subcontractors, and Network Providers comply with any applicable provisions of the MOU;

5) Provide education and training of MOU as required by Exhibit A, Attachment III, Subsection 5.6.2.A.12) above;

6) If DHCS requests a review of any existing MOU, Contractor must submit the requested MOU within ten Working Days of receipt of the request;

7) Ensure appropriate committee representation by inviting a local presence in advance to each quarterly meeting an opportunity to discuss and address Care Coordination and MOU-related issues with county executives;

8) Ensure an appropriate level of leadership are invited to participate in MOU engagements from both Contractor and entity as appropriate; and

9) Report to DHCS updates from quarterly meetings in a manner and frequency specified by DHCS through APLs and guidance.

B. MOU Compliance Requirements

1) At a minimum, executed MOUs listed in this Exhibit A, Attachment III, Subsection 5.6.1 (*MOU Purpose*) must be submitted to DHCS.

2) To the extent Contractor does not execute MOU within the timeframe required under this Contract and relevant APLs, Contractor must submit quarterly reports to DHCS documenting its continuing good faith efforts to execute the MOU, until such time as the MOU is executed. Documentation of good faith efforts must include a description of attempts made to execute an MOU and the explanation for why the MOU has not been executed.

3) Contractor, at a minimum, must review its MOUs annually for any needed modifications or renewal of responsibilities and obligations outlined within. Contractor must submit to DHCS' Contract Manager evidence of the annual review of MOUs as part of their annual report in accordance with APL 23-029, as well as copies of any MOUs modified or renewed as a result. The annual report is due each year on the last business day of January and must be posted to Contractor's website within 30 calendar days of the report due date.

4) Contractor must report on its compliance with the MOU to Contractor's compliance officer at least on a quarterly basis.

Exhibit A, ATTACHMENT III

6.0 Emergency Preparedness and Response

This Article's provisions make explicit DHCS' commitment to ensuring that the Medi-Cal managed care delivery system is prepared for those unforeseen circumstances that require immediate action. Specifically, Contractors must plan for and ensure continuity of business operations, delivery of essential care and services to Members, and mitigate potential harm caused by Emergencies, such as a natural or manmade disaster or public health crisis. This Article includes provisions requiring that Contractor must maintain an Emergency Preparedness and Response Plan, including a Business Continuity Plan and Member Emergency Preparedness Plan. In addition, during a federal, State, or county declared state of Emergency, Contractor must implement protocols that allow Members timely access to Covered Services including by allowing flexibility for Prior Authorization, pre-certification, and referrals.

6.1 Emergency Preparedness and Response

6.1.1 General Requirements
6.1.2 Business Continuity Emergency Plan
6.1.3 Member Emergency Preparedness Plan
6.1.4 California's Standardized Emergency Management System
6.1.5 Reporting Requirements During an Emergency
6.1.6 DHCS Emergency Directives

6.1 Emergency Preparedness and Response

6.1.1 General Requirements

For the purposes of this Article 6.0 (*Emergency Preparedness and Response*), "Emergency" means unforeseen circumstances that require immediate action or assistance to alleviate or prevent harm or damage caused by public health crises, natural and man-made hazards, or disasters.

For the purposes of this Article 6.0 (*Emergency Preparedness and Response*), "Emergency Preparedness" means a continuous cycle of planning, organizing, training, equipping, exercising, evaluating, and taking Corrective Action in an effort to ensure effective coordination during incident response. Contractor's Emergency Preparedness process is one element of a broader national preparedness system to prevent, respond to, and recover from public health crises, natural disasters, acts of terrorism, and other disasters.

For the purposes of this Article 6.0 (*Emergency Preparedness and Response*), "Emergency Preparedness and Response Plan" means an Emergency plan put in place by Contractor to ensure continuity of its business operations, to ensure delivery of essential care and services to Members, and to help mitigate potential harm caused by an Emergency.

Nothing in this Article 6.0 (*Emergency Preparedness and Response*) is intended to relieve Contractor of any other duties or requirements that would otherwise apply, such as any duties or requirements under federal and State laws and regulations relating to Emergency Preparedness.

Contractor must have in place an Emergency Preparedness and Response Plan which includes, at a minimum

A. A Business Continuity Emergency Plan, as described in Exhibit A, Attachment III, Section 6.1.2 *(Business Continuity Emergency Plan*)*;*

B. A Member Emergency Preparedness Plan, as described in Exhibit A, Attachment III, Section 6.1.3 *(Member Emergency Preparedness Plan*)*;* and

C. Contractor's policies and procedures for complying with all of the requirements set forth in this Article 6.0 (*Emergency Preparedness and Response*).

Contractor must submit its Emergency Preparedness and Response Plan to DHCS for approval prior to the start of Contractor's operations. Contractor must submit any updates to deliverables identified in this Section to DHCS as requested.

6.1.2 Business Continuity Emergency Plan

Contractor must have a Business Continuity Emergency Plan in place to deal with any Emergency that may affect Contractor's business operations, including, but not limited to, access to Network Providers, Subcontractors, and Downstream Subcontractors; communications; staffing; supplies; and information technology concerns.

For the purposes of this Article 6.0 (*Emergency Preparedness and Response*), a "Business Continuity Emergency Plan" means a document consisting of the critical information and processes Contractor needs to continue operating during an Emergency.

Contractor must consider the availability of local resources and requirements and, upon request, coordinate with local city and county Emergency Preparedness programs when establishing its Business Continuity Emergency Plan.

At a minimum, Contractor's Business Continuity Emergency Plan must address the following:

A. Communication

Contractor must describe how it will communicate with staff, Network Providers, Subcontractors, Downstream Subcontractors, DHCS, and other essential persons and entities during an Emergency. Contractor must also include how Contractor will provide Member, Network Provider, Subcontractor, and Downstream Subcontractor access to call centers for questions; how Contractor will provide dedicated staff and resources toward the Emergency process; and how Contractor will address the continual and timely resolution of claims. Contractor must maintain Emergency contact information, telephone numbers, and other contact information (including contact name, title or position, physical location address, mailing address, telephone and/or cell phone, text, e-mail, and social media) for staff, Network Providers, Subcontractors, Downstream Subcontractors, and other essential persons and entities. Contractor must update this contact information as changes occur, but no less than every six months.

B. Emergency Preparedness Risk Assessment

Contractor must identify and assess potential public health crises and natural or man-made Emergencies, including, but not limited to, epidemics, pandemics, earthquakes, fires, floods, storms, hurricanes, tornados, power outages, gas leaks, bomb threats or presence of

explosives, explosions, hazardous materials incidents, relocations or evacuations, assaults, intrusions, bioterrorism, injuries, riots, and information technology security incidents that could arise at any location in which Contractor conducts business operations under this Contract. When assessing the risk of a potential Emergency, Contractor must consider the likelihood of the Emergency within its Service Area and how the Emergency may disrupt Contractor's business operations. Contractor must identify and assess any essential supply chain impacts that may disrupt business operations during or after the Emergency. Contractor must update its assessment as changes occur, but at least on an annual basis.

C. Emergency Team Staffing and Responsibilities

1) Contractor must identify an Emergency team and back-up Emergency team members to carry out Contractor's Business Continuity Emergency Plan in the event of an Emergency.

2) Contractor must clearly designate the Emergency team's responsibilities during an Emergency, including, but not limited to, sending out Emergency communications to Contractor's employees, Network Providers, Subcontractors, Downstream Subcontractors, Members, managing site security staff, those staff responsible for securing utilities, and other essential persons and entities.

3) Contractor must ensure that Emergency team members know how to report their status to the Emergency team during and after an Emergency to keep Contractor informed of changing needs.

D. Cooperative Arrangements

Contractor must attempt to establish cooperative arrangements with other local health care organizations to assist and provide mutual aid during an Emergency when business operations are affected. Contractor must submit to DHCS an attestation that it will update its cooperative arrangements at least annually.

E. Training and Drills

1) Contractor must establish an Emergency training program to train new and existing staff on Contractor's Business Continuity Emergency Plan.

2) Contractor must conduct annual Business Continuity Emergency Plan drills to ensure Emergency Preparedness and to detect

vulnerabilities that can be addressed before an actual Emergency arises. Contractor must submit a report to DHCS within 30 calendar days of each training drill which identifies drill activities, provides a summary of outcomes, and creates a plan to address any vulnerabilities found.

3) Contractor must, upon request, participate in mock disaster drills coordinated by governmental entities, if available, to ensure coordination during an Emergency.

4) Contractor must ensure that the equipment and supplies necessary to sustain business operations are readily available in the event of an Emergency.

F. Systems Recovery

1) Emergency Operation

Contractor must establish a plan to maintain critical business processes that protects confidential and sensitive electronic and non-electronic information, including, but not limited to, Protected Health Information (PHI), personal information, and claims information during an Emergency.

2) Data Backup

Contractor must establish procedures to backup confidential and sensitive electronic information, including, but not limited to, PHI, PI, and claims information to maintain the ability to retrieve such information during an Emergency. Contractor must establish a regular schedule for conducting backup procedures, storing backup information offsite, updating an inventory of backup media, and formulating an estimate for the time needed to restore lost confidential and sensitive information. At a minimum, Contractor must conduct a full backup process of its confidential and sensitive electronic information on a weekly basis and update its offsite data storage on a monthly basis.

6.1.3 Member Emergency Preparedness Plan

Contractor must establish a Member Emergency Preparedness Plan to address its Members' needs during an Emergency, including for Members in Long-Term Care facilities, Skilled Nursing Facilities, or other institutional settings; and for Members with disabilities, limitations in activities of daily living, and/or cognitive impairments.

For the purposes of this Article 6.0 (*Emergency Preparedness and Response*), a "Member Emergency Preparedness Plan" means a required subsection of the Emergency Preparedness and Response Plan that details the required coordination between Contractor and its Members, Network Providers, Subcontractors, and Downstream Subcontractors to ensure Member access to health care services in the event of an Emergency.

At a minimum, Contractor's Member Emergency Preparedness Plan must address the following:

A. Member Communication

1) Contractor must have the ability to set up a Member services call center for communication with Members before, during, and after an Emergency.

2) Contractor must establish Emergency protocols for its Member services call center. Protocols must include, but are not limited to, call scripts that account for different Member needs, staff training in crisis response, Contractor Emergency protocols that ensure access to Covered Services, and processes for escalating a call through warm hand-off connections to nurses or doctors for Members needing immediate assistance.

3) During and post-Emergency, Contractor must:

a) Instruct Members about how to reach Contractor's nurse advice line, care coordinators, Medi-Cal Rx pharmacy services, Telehealth services, and other Contractor services and resources as deemed appropriate;

b) Notify Members about available alternative primary pharmacy, dialysis center, chemotherapy or other infusion therapy location, and other treatment sites;

c) Inform Members about how Contractor may modify its care protocols and Member benefits to ensure continued access to Medically Necessary services;

d) Provide Members with information on how to obtain medical authorizations, out-of-Network care, medication refills or Emergency supply, Durable Medical Equipment (DME) and replacements, and Medical Records; and

e) Inform Members about how to access behavioral and mental health services.

B. Continuity of Covered Services

1) Contractor must ensure that Members impacted by a federal, State, or county declared state of Emergency continue to have access to Covered Services. Contractor must take actions to ensure continued access, including but not limited to the following:

a) Relaxing time limits for Prior Authorization, pre-certification, and referrals;

b) Extending filing deadlines for Grievances and requests for Appeal in accordance with Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*);

c) Coordinating, transferring, and referring Members to alternate sources of care when Providers are closed, unable to meet the demands of a medical surge, or otherwise affected by an Emergency;

d) Authorizing Members to replace DME or medical supplies out-of-Network;

e) Allowing Members to access appropriate out-of-Network Providers if Network Providers are unavailable due to an Emergency or if the Member is outside of the Service Area due to displacement; and

f) Providing, when directed, a toll-free telephone number for displaced Members to call with questions, including questions about the loss of a Beneficiary Identification Card, access to prescription refills, and how to access health care.

2) Contractor must establish policies and procedures to immediately implement these actions as necessary or as directed by DHCS.

C. Network Provider, Subcontractor, and Downstream Subcontractor Emergency Requirements

1) Education

a) Contractor must educate Network Providers, as a part of training in accordance with Exhibit A, Attachment III, Subsection 3.2.5 (*Network Provider Training*); Subcontractors; and Downstream Subcontractors on Contractor’s Emergency policies and procedures.

b) Contractor must provide Network Providers, Subcontractors, and Downstream Subcontractors with an Emergency Preparedness fact sheet and resources on general Emergency Preparedness, response, and communications protocols.

2) Communications During an Emergency

a) Contractor must have a system and process in place to be able to provide and receive information from Network Providers, Subcontractors, and Downstream Subcontractors during an Emergency.

b) Contractor must have a process in place to inform Network Providers, Subcontractors, and Downstream Subcontractors about what modifications need to be implemented during an Emergency to ensure that Members are able to access Covered Services, and how Contractor can assist Network Providers, Subcontractors, and Downstream Subcontractors in those efforts.

3) Network Provider Agreements

a) Contractor's Network Provider Agreements must state that Network Providers are required to:

i. Annually submit evidence of adherence to Centers for Medicare & Medicaid Services (CMS) Emergency Preparedness Final Rule (FR), 81 FR 63859, and 84 FR 51732;

ii. Advise Contractor as part of the Network Provider's Emergency plan; and

iii. Notify Contractor within 24 hours of an Emergency if the Network Provider closes down, is unable to meet the demands of a medical surge, or is otherwise affected by an Emergency.

6.1.4 California's Standardized Emergency Management System

A. Contractor must cooperate with local city and county Emergency Preparedness programs within Contractor's Service Area to ensure provision of health care services.

B. Contractor must, upon request, educate and prepare staff on the California State Emergency Plan and prepare staff to participate in California's Standardized Emergency Management System (SEMS).

C. Contractor must maintain contact information for local city and county Emergency Preparedness programs within Contractor's Service Area.

D. Contractor must ensure that its medical director and Grievance and Appeals coordinator are able to receive communications from the California Health Alert Network and the California State Warning Center.

6.1.5 Reporting Requirements During an Emergency

A. Within 24 hours of a federal, State, or county declared state of Emergency located within Contractor's Service Area, Contractor must notify DHCS as to whether Contractor has experienced or expects to experience any disruption to its operations.

B. At a minimum, Contractor must report the status of its operations once a day to DHCS, or as directed by DHCS.

C. Contractor's daily report to DHCS must include, at a minimum, the following information:

1) The number of Members in Contractor's Service Area affected by the Emergency, per county, including the number of medium-to-high health risk Members, as identified through the Population Needs Assessment;

2) Information, to the extent available, relating to Network Provider site closures, including:

a) The number of Network Provider site closures by Provider type, per county;

b) The number of Members served by each closed Network Provider, per county;

c) The number of hospitalized Members who need to be transferred;

d) The location(s) of where Members were transferred; and

e) For each closed Network Provider, a list of the alternative Providers or facilities where Members can receive care.

3) The number of Contractor offices that are closed;

4) How Contractor is communicating with impacted Members, Network Providers, Subcontractors, and Downstream Subcontractors;

5) The actions Contractor has taken or will take to meet the continued health care needs of its Members; and

6) The Network Provider, Subcontractor, Downstream Subcontractor, or Member issues Contractor has received.

D. Contractor must comply with any guidance from the California Health and Human Services Agency regarding reporting on the status of Contractor's operations during an Emergency.

6.1.6 DHCS Emergency Directives

When a federal, State, or county Emergency is declared, Contractor agrees that DHCS may, in its sole discretion, waive existing contractual requirements and institute new contractual requirements to address an Emergency pursuant to an Emergency directive. DHCS Emergency directives do not require an amendment to this Contract prior to implementation. Emergency directives to Contractor may be communicated through All Plan Letters, advisory memos, or other similar announcements and are effective when published. Unless otherwise stated, Emergency directives will remain in effect until the Emergency directive is terminated. Contractor must promptly comply with all DHCS Emergency directives.

Exhibit A, Attachment III

7.0 Operations Deliverables and Requirements

To demonstrate the requisite capabilities necessary to execute the obligations of this Contract, DHCS outlines specific deliverables that Contractor must submit to DHCS prior to the implementation of the Contract. This period is considered the Implementation Period at which time DHCS will assess the Medi-Cal managed care plan's readiness to begin operations as a Contractor. These deliverables are identified and set forth in Exhibit A, Attachment II, Section 1.0 (*Operational Readiness Deliverables and Requirements*) of the Contract and the tables that follow that Section.

This Article provides a non-exhaustive list of deliverables required to be submitted by Contractor to DHCS and/or other entity(ies) throughout the term of the Contract to verify Contractor's continued compliance with Contract requirements. Contractor must submit all required deliverables to DHCS in a complete, accurate, and timely fashion. Contractor must submit all required deliverables to DHCS in an ADA-compliant format if identified in the tables below this section as publicly available. Contractor may be responsible for additional deliverable requirements based on changes in State and federal law and/or DHCS program needs. Contractor must meet any additional requirements, not listed in the tables below, upon DHCS' request and in the form and manner specified by DHCS. Contractor must use the calendar year to define annual, monthly, and quarterly submission timeframes unless directed otherwise.

In the event Contractor fails to submit any deliverables in accordance with the milestones and timeframes required by DHCS, DHCS may impose Sanctions and Liquidated Damages in accordance with Exhibit E, Section 1.19 (*Sanctions*) and Section 1.20 (*Liquidated Damages*) to Contractor.

EXHIBIT A, ATTACHMENT I – 1.0 DEFINITIONS

No deliverables or requirements listed for this Article.

EXHIBIT A, ATTACHMENT I – 2.0 ACRONYMS

No deliverables or requirements listed for this Article.

EXHIBIT A, ATTACHMENT II – 1.0 OPERATIONAL READINESS DELIVERABLES AND REQUIREMENTS

See specific contract Sections below for details.

EXHIBIT A, ATTACHMENT III – 1.1 PLAN ORGANIZATION AND ADMINISTRATION

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0001	Key Personnel Disclosure Form	1.1.2	Annually.		DHCS
D.0114	Medical Director Information	1.1.6	Attest to DHCS that this has been posted no later than January 1 of each year.	Posted in an easily accessible location on Contractor's Provider portal website.	Public
Via Notifi-cation Center	Key Personnel Change Notification including CEO, CFO, COO, CMO, Chief Medical Director, Health Equity Officer, Compliance Officer, and Government Relations Person.	1.1.8	Within ten calendar days.	Contractor must post Medical director contact information on their provider portal website.	DHCS; Public

EXHIBIT A, ATTACHMENT III – 1.2 FINANCIAL INFORMATION

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0003	Monthly Financial Reports	1.2.2	Monthly, no later than 30 calendar days after the close of Contractor's fiscal month.	Financial Reports submitted in accordance with this Section 1.2 are public records and may be made public by DHCS.	DHCS
D.0004	Quarterly Financial Reports	1.2.2	Quarterly, no later than 45 calendar days after the close of Contractor's fiscal quarter.		DHCS
D.0005	Annual Financial Reports	1.2.2	Annually, no later than 120 calendar days after the close of Contractor's Fiscal Year.		DHCS
D.0006	Annual Forecasts	1.2.2	Annually, no later than 60 calendar days prior to the beginning of Contractor's next Fiscal Year.		DHCS
D.0007	Independent Financial Audit Report	1.2.3	Annually, no later than 120 calendar days after the close of Contractor's Fiscal Year.		DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0008	Medical Loss Ratio Report (MLR)	1.2.5; 1.2.5.H	Annually Timeframe and manner determined by DHCS, but no longer than 12 months after the end of the MLR reporting year; and when there is a retroactive change to the Capitation Payments for a MLR reporting year and a new report needs to be submitted to reflect the change.		DHCS
D.0009	Community Reinvestment Plan	1.2.7	Annually.	Posted on Contractor's website.	DHCS
D.0010	Community Reinvestment Report	1.2.7	Annually.	Posted on Contractor's website.	DHCS

EXHIBIT A, ATTACHMENT III – 1.3 PROGRAM INTEGRITY AND COMPLIANCE PROGRAM

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0115	Compliance Program	1.3.1.A.9)	Annually.	On Contractor's website.	DHCS
D.0011	Preliminary Fraud, Waste, and Abuse Reports	1.3.2.D.1)	Within ten Working Days of Contractor's discovery of such Fraud, Waste, or Abuse.		DHCS
D.0012	Completed Fraud, Waste, and Abuse Investigation Report	1.3.2.D.2)	Within ten Working Days of completing Contractor's Fraud, Waste, or Abuse investigation.		DHCS
D.0013	Quarterly Fraud, Waste, Abuse Status Report	1.3.2.D.3)	Quarterly, within ten Working Days after the close of every calendar quarter.		DHCS
D.0014	Suspended, Excluded, or Ineligible Provider Notification	1.3.4.A.6)	Within ten Working Days of removing a suspended, excluded, or ineligible Provider from its Network.		DHCS
D.0116	Disclosures	1.3.5.C	Within 60 calendar days of when it has identified any Capitation Payments or other payments it has received or paid in excess of the amounts specified in this Contract.		
D.0131	Overpayment Notification of any amount, including overpayments related to Fraud, Waste, and Abuse	1.3.6.A	Within 30 calendar days of the date of the identification of the overpayment.		DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0106	Overpayment Recoveries Report	1.3.6.B	Annually.		DHCS

EXHIBIT A, ATTACHMENT III – 2.1 MANAGEMENT INFORMATION SYSTEM

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0015	Encounter Data Reporting	2.1.2	Within 60 calendar days of the date of adjudication of a claim or receipt of an Encounter as required by this Contract or as otherwise agreed upon by DHCS, or as mandated through federal law; Within six Working Days of the end of each month following the month of payment.		DHCS
D.0017	Network Provider Data Reporting	2.1.4	Within ten calendar days following the end of each month.		DHCS
D.0018	Program Data Reporting	2.1.5	Within ten calendar days following the end of each month.		DHCS
D.0019	Template Data Reporting	2.1.6	On a regular basis, or as mandated through federal law.		DHCS
D.0020	Management Information System/Data Audits	2.1.7	No less frequently than once every three years.		DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0016	Data Corrective Action Plans	2.1.8	Within 15 calendar days from the date of the DHCS written notice to Contractor regarding any deficiencies and problems related to Contractor's data or its Management and Information System (MIS).	DHCS may publicly disclose on the DHCS website any Contractors that have entered into Corrective Action plans, or that have been subject to sanctions due to non-compliance.	DHCS; public
D.0117	Tracking Member Alternative Format Selections	2.1.9	As requested by Member in accordance with the requirements in APL 25-016. Annually attest to compliance with APL 25-016.		DHCS

EXHIBIT A, ATTACHMENT III – 2.2 QUALITY IMPROVEMENT AND HEALTH EQUITY TRANSFORMATION PROGRAM

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0021	Written summary of Quality Improvement and Health Equity Committee (QIHEC) activities, as well as the QIHEC activities of Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors	2.2.3.D	At least quarterly.	On Contractor's website.	DHCS; Public
D.0022	Quality Improvement and Health Equity Plan	2.2.7	Annually.	On Contractor's website.	DHCS; Public
D.0026	NCQA Health Plan Accreditation and Health Equity Accreditation results	2.2.8	After every NCQA accreditation cycle (every three years). Within 30 calendar days of the receipt of the completed report from NCQA. Within 15 calendar days of confirmation of the site visit by NCQA.		DHCS
D.0024	Health plan Subcontractor and Downstream Subcontractor quality and health equity performance data	2.2.9.A.2	Annually (and as requested by DHCS).		DHCS
D.0023	Performance Improvement Project reporting	2.2.9.B	At intervals determined by DHCS. At least annually.	On the DHCS website.	DHCS; Public

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0025	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey results and CAHPS results for its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors	2.2.9.C	Annually after January 1, 2026.	On Contractor's website.	DHCS; Public
D.0141	EPSDT/AAP Bright Futures annual attestation for mailing/electronically sharing of DHCS supplied Medi-Cal for Kids and Teens Materials	2.2.10. B.2	Annually, by January 15th.	Yes	Eligible Members under the age of 21. New Members within seven calendar days of Enrollment
D.0144	Long-Term Care Quality Assurance and Performance Improvement (QAPI) program	2.2.11	Annually, by January 31st.		DHCS

EXHIBIT A, ATTACHMENT III – 2.3 UTILIZATION MANAGEMENT PROGRAM

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0027	Appeals Procedure	2.3.1.F	As needed when updated.	On Contractor's website.	DHCS; Public
D.0142	Contractor's internal reporting mechanisms used to detect Member utilization and Provider prescribing patterns	2.3.3	No later than 30 calendar days after the beginning of each calendar year and upon DHCS request.		DHCS

EXHIBIT A, ATTACHMENT III – 3.1 NETWORK PROVIDER AGREEMENTS, SUBCONTRACTOR AGREEMENTS, DOWNSTREAM SUBCONTRACTOR AGREEMENTS, AND CONTRACTOR'S OVERSIGHT DUTIES

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0132	Network Provider Agreement Template	3.1.2.A.1	When updated or when a new provider type.		DHCS
D.0133	Subcontractor Agreement Template	3.1.2.B.1.a	When updated or when a new provider type.		DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0134	Updates to Fully Delegated Subcontractor Agreements Template with Fully Delegated Downstream Subcontractors	3.1.2.B.1.a	As needed when updated.		DHCS
D.0135	Updates to Fully Delegated Executed Subcontractor Agreements with Fully Delegated Downstream Subcontractors	3.1.2.B.1.b	As needed when updated.		DHCS
D.0028	Delegation Reporting and Compliance Plan	3.1.3; Exh. J	Annually and at any time there is a material change as specified by DHCS within 30 calendar days from either the beginning of the annual reporting period or the material change.	On Contractor's website.	DHCS; Public
D.0031	Termination Notice of Network Provider Agreement with a Safety-Net Provider	3.1.8	As needed, at least 60 calendar days prior to the effective date of termination or concurrently with the termination if Provider's license has been revoked or suspended or where the health and welfare of a Member is threatened.		DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0118	Provider Selection	3.1.10	Upon request.		DHCS
D.0119	Delegation Model	3.1.12		On Contractor's website	

EXHIBIT A, ATTACHMENT III – 3.2 PROVIDER RELATIONS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0032	Provider Dispute Resolutions Report	3.2.2	Annually.		DHCS
D.0033	Most current Provider Manual	3.2.4	As needed. Annually.	Available to the Provider through Provider portals, the Internet or upon request.	Providers
D.0034	Hospital Inpatient Days Report	3.2.8	As required by Welfare and Institutions Code (W&I) section 14105.985(b)(2). Within 30 calendar days of DHCS' request.		DHCS

EXHIBIT A, ATTACHMENT III – 3.3 PROVIDER COMPENSATION ARRANGEMENTS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0035	Alternative and Value-Based Payment Models Report	3.3.1.B C	Within 90 calendar days of DHCS' request. Annually.		DHCS
D.0036	Financial Incentive Programs Report	3.3.3	As specified by DHCS.		DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0037	Identification of Responsible Payor	3.3.4	Upon request and in a manner prescribed by DHCS.		DHCS' fiscal intermediary (FI) contractor
D.0038	Documentation of services for Contractor's Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) Network Provider Agreements	3.3.7.B	Within 30 calendar days of DHCS' request.		DHCS
D.0039	Certification of Terms and Conditions for Network Provider Agreements with FQHCs and RHCs	3.3.7.B	Within 30 calendar days of DHCS' request.		DHCS
D.0040	FQHC and RHC Network Provider Agreements	3.3.7.B	Whenever any Network Provider Agreements are executed or amended.		DHCS
D.0041	Disputed Emergency Services/Post-Stabilization Care Claims	3.3.16	As needed. Within 30 calendar days of the effective date of a decision that Contractor is liable for payment of a claim.		DHCS - Office of Administrative Hearings and Appeals

EXHIBIT A, ATTACHMENT III – 4.1 MARKETING

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0042	Request to Conduct Activity Outside of Contract Requirements	4.1.2	As needed, at least 30 calendar days prior to the Marketing event.		DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0043	Updates to Marketing Representative Training and Certification Program	4.1.1	Prior to implementation.		DHCS
D.0044	Marketing Materials	4.1.2	Prior to distribution. At least 30 calendar days prior to the Marketing activity, unless DHCS agrees to a shorter review period.		DHCS
D.0045	Marketing Plan	4.1.2	Annually. When there are any changes made to Contractor's Marketing plan.		DHCS

EXHIBIT A, ATTACHMENT III – 4.2 ENROLLMENTS AND DISENROLLMENTS

No deliverables or requirements listed for this Section.

EXHIBIT A, ATTACHMENT III – 4.3 POPULATION HEALTH MANAGEMENT AND COORDINATION OF CARE

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0046	Population Health Management Strategy	4.3.1	Annually.		DHCS
D.0047	Population Needs Assessment	4.3.2	At least every three years.	On Contractor's website.	DHCS; Public
D.0048	Managed Care Liaison Change Notification	4.3.24	Within five days of the change.		DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0136	NSMHS Outreach and Education Plan Submission to DHCS	4.3.12	Annually.		DHCS
D.0137	DHCS Approved NSMHS Outreach and Education Plan & Utilization Assessment Posting	4.3.12	Annually.	On Contractor's website.	DHCS; Public

EXHIBIT A, ATTACHMENT III – 4.4 ENHANCED CARE MANAGEMENT

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0049	Enhanced Care Management Model of Care (MOC)	4.4.5	Contractor must submit to DHCS any Significant Changes to its MOC for DHCS review and approval at least 60 calendar days in advance of any occurrence of changes or updates, in accordance with DHCS policies and guidance, including APLs.		DHCS

EXHIBIT A, ATTACHMENT III – 4.5 COMMUNITY SUPPORTS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0050	Community Supports Model of Care	4.5.6	Contractor must submit to DHCS any changes to its Community Supports MOC for DHCS review and approval at least 60 calendar days in advance of any occurrence of changes or updates, in accordance with DHCS policies and guidance, including APLs.		DHCS

EXHIBIT A, ATTACHMENT III – 4.6 MEMBER GRIEVANCE AND APPEAL SYSTEM

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0051	Receipt of Standard Grievances	4.6.2.E	Within five calendar days of receipt of the Grievance.		Member who filed a Grievance
D.0052	Discrimination Grievance Information	4.6.3.C	Within ten calendar days of mailing a Discrimination Grievance resolution letter. Contractor must also submit annual attestation on second Friday of December indicating Contractor submitted appropriate grievance information to OCR within ten calendar days of mailing Discrimination Grievance resolution letter.	On Contractor's website.	DHCS – Office of Civil Rights; DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0053	Sample Notice of Action (NOA) Letter	4.6.4.C 4.6.4.E.3	Within 30 calendar days from receipt of information that is reasonably necessary to make a determination. No later than 60 calendar days from the date on the NOA.		DHCS
D.0054	Grievance Logs	4.6.9	Upon DHCS request.		DHCS and/or CMS

EXHIBIT A, ATTACHMENT III – 5.1 MEMBER SERVICES

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0056	Nondiscrimination Notice and Language Taglines	5.1.3	Prior to use.	On Contractor's website – accessible from Contractor's home page.	DHCS
D.0057	Member Information – Provider Directory	5.1.3	Prior to initial Operations; Monthly; Every six months; and When Contractor updates the Provider Directory. One week after Contractor receives updated provider information.	On Contractor's website.	DHCS; Public
D.0058	Member Information – Member Handbook/Evidence of Coverage (EOC)	5.1.3	Before distribution to Members; When updated; or Other timeframes provided by DHCS.	On Contractor's website.	DHCS
D.0139	Attestation whether Contractor meets 5.1.3.A & B requirements for mailing new/potential member materials within seven calendar days	5.1.3.A 5.1.3.B	Monthly by end of month.	No.	DHCS
D.0140	Attestation whether Contractor meets annual mailing requirements	5.1.3.C	Annually by end of January.	No.	DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0129	EOC Attestation-Notification to DHCS that the EOC has been mailed and/or posted on the Contractor's Website by January 1st.	5.1.3	Annually, by January 2nd.		DHCS
D.0143	Contractual Website Requirement	Various-Refer to Review Tool	Annually.	On Contractor's website.	DHCS

EXHIBIT A, ATTACHMENT III – 5.2 NETWORK AND ACCESS TO CARE

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0059	Alternative Access Standard Requests	5.2.5	At least annually and when Contractor is unable to comply with the time or distance standards set forth in W&I section 14197.04.	Contractor's website for Contractor specific results and the DHCS website with statewide results.	DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0060	Network and Access Changes to Covered Services	5.2.9.A	When Contractor discovers a Provider-initiated termination impacting more than 2,000 Members; When Contractor discovers a Provider-initiated termination that affects Contractor's ability to meet network adequacy standards; When there is a change in the availability or location of Covered Services; and Within ten calendar days of Contractor discovering a Provider's exclusionary status from any database or list.		DHCS
D.0061	Notification regarding Community Based Adult Services (CBAS) Network Provider	5.2.9.A	When Contractor is unable to contract with a certified CBAS Provider; Upon termination of a CBAS Network Provider Agreement; and Within five Working Days of Contractor's decision to exclude a CBAS Provider from its Network.		DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0062	Notification regarding Long-Term Care (LTC) Network Provider	5.2.9.A.4	Within 60 calendar days of termination of a LTC Provider; Immediately if the termination is a result of LTC Provider decertification by CDPH; and Within 72 hours of applicable termination of a LTC Provider.		DHCS
D.0063	Member Notice regarding Provider Termination	5.2.9.B	Prior to its release to Members.		DHCS
D.0064	Community Advisory Committee (CAC) Demographic Report	5.2.11	Annually, by April 1st.		DHCS
D.0065	CAC meeting notices	5.2.11	30 days prior to each quarterly CAC meeting, but in no event later than 72 hours prior to each meeting.	On Contractor's website.	Public
D.0066	CAC meeting minutes	5.2.11.E 3)d)	No later than 45 calendar days after each quarterly meeting.	On Contractor's website.	DHCS; Public
D.0067	Network Certification Report	5.2.13	At least annually.	On the DHCS Website.	DHCS
D.0068	Notification of Significant Change to Network	5.2.13.B	Any time there is a Significant Change to Contractor's Network that affects Network capacity and Contractor's ability to provide health care services.		DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0069	Network Change Report	5.2.13	30 calendar days following the end of the reporting quarter.		DHCS
D.0112	Subcontractor and Downstream Subcontractor Certification Report	5.2.13	At least annually, if applicable.	On Contractor's website.	DHCS

EXHIBIT A, ATTACHMENT III – 5.3 SCOPE OF SERVICES

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0070	Report of Drug Use Review (DUR) Program Activities	5.3.7.H	Annually, by June 1st.		DHCS

EXHIBIT A, ATTACHMENT III – 5.4 COMMUNITY BASED ADULT SERVICES

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0072	CBAS Member Enrollment Report	5.4.3.A	On a quarterly basis.		DHCS
D.0113	Summary of CBAS Complaints	5.4.3.C	30 calendar days following the end of the reporting period.		DHCS
D.0073	CBAS Grievance and Appeal Reports	5.4.3.D	30 calendar days following the end of the reporting period.		DHCS
D.0120	CBAS Provider List	5.4.3.E	Annually.		DHCS

EXHIBIT A, ATTACHMENT III – 5.5 MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS

No deliverables or requirements listed for this Section.

EXHIBIT A, ATTACHMENT III – 5.6 MOUs WITH LOCAL GOVERNMENT AGENCIES, COUNTY PROGRAMS, AND THIRD PARTIES

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0130	Revised MOU Template	5.6.1.C.2	As needed.	After execution	DHCS
D.0075	Status Report	5.6.3	Quarterly, beginning four months after the effective date of this Contract or within the timeframe required under this Contract and relevant APL, until all required MOUs are executed.		DHCS
D.0127	MOU Liaison Change Notification	5.6.3.A.3	Within five Working Days of any change in the designated MOUs' liaison.		DHCS
D.0121	Existing MOU	5.3.6.A.6	Within ten Working Days of receipt of the request.		DHCS
D.0076	Copy of Executed MOUs	5.6.3	Upon execution, modification or renewal.	On Contractor's website.	DHCS
D.0077	MOU Annual Report	5.6.3.B	Annually, by the last business day in January.	Posted on Contractor's website within 30 days of the report due date.	Public and DHCS

EXHIBIT A, ATTACHMENT III – 6.1 EMERGENCY PREPAREDNESS AND RESPONSE

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0078	Emergency Preparedness and Response Plan	6.1	Prior to the start of Operations.	On Contractor's website.	DHCS
D.0079	Emergency Contact Information Update	6.1.2.A	No less than every six months; and As changes occur.		DHCS
D.0080	Cooperative Agreements	6.1.2.D	At least annually.		DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0081	Emergency Drill Report	6.1.2.E	Within 30 calendar days after the drill is completed.		DHCS
D.0082	Member Emergency Preparedness Plan Templates	6.1.3	Prior to use for each mode of communication.		DHCS
D.0083	Daily Emergency Reporting	6.1.5.B	Once a day, at a minimum, throughout the State of Emergency.		DHCS

EXHIBIT B, BUDGET DETAIL AND PAYMENT PROVISIONS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0084	Supplemental Payments Report	1.1.7.A	On a monthly basis no later than 20 calendar days following the end of each month.		DHCS
D.0085	Supplement Payment Eligibility Data	1.1.7.A	Contractor must properly submit all required data to DHCS within 12 months of the month of the service entitling Contractor to a Supplemental Payment.		DHCS
D.0086	Additional Payments Report	1.1.8.A	On a monthly basis, no later than 20 calendar days following the end of each month.		DHCS
D.0087	Additional Payments Report Eligibility Data	1.1.8.A	Contractor must properly submit all required data to DHCS within 12 months of the month of the service entitling Contractor to an additional payment.		DHCS
D.0122	Financial Performance Guarantee	1.1.12	Annually.		DHCS
D.0088	Medical Loss Ratio Remittance	1.1.15	When the ratio for the MLR reporting year does not meet the minimum MLR standard.		DHCS

EXHIBIT C, GENERAL TERMS AND CONDITIONS

No deliverables or requirements listed for this Exhibit.

EXHIBIT D(f), SPECIAL TERMS AND CONDITIONS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0094	Request for Subcontract Authorization	5.a	Before Contractor enters into or is reimbursed for any subcontract for services costing $5,000 or more.		DHCS
D.0096	Requests for Disclosure of Confidential Information	14	As applicable.		DHCS
D.0097	Contractor Certification of Federal Fund Expenditure	17.c	As applicable.		DHCS
D.0098	Financial and Compliance Audit Reports	17.d	Within 30 calendar days after the completion of the audit.		DHCS
D.0099	Contractor Explanation for Debarment and Suspension Certification.	20	As applicable.		DHCS

EXHIBIT E, PROGRAM TERMS AND CONDITIONS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0123	Certifications – Data, Information, and Documentation Submitted to DHCS	1.1.11	Monthly.		DHCS
D.0100	Contractor's Analysis regarding its financial solvency	1.1.16	As needed.		DHCS
D.0101	Contractor Termination Notice due to financial insolvency	1.1.16	As needed, and at least six months prior to expected effective termination date.		DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0124	Phaseout Transition Requirements	1.1.17.B	Within no later than 90 calendar days prior to termination or expiration of this Contract and through the Phaseout Period for each Service Area.		DHCS
D.0102	Notice of Dispute	1.1.21.B	Within 30 calendar days from the date that the alleged dispute arises or otherwise becomes known to Contractor.		DHCS
D.0103	Costs Avoidance Reports	1.1.25	Within ten calendar days of discovery By the 15th day of each month.		DHCS
D.0104	Post-Payment Recovery Report	1.1.25.H 1.1.25.J	At the tenth day of each month; and Within ten calendar days of discovery when Contractor identifies OHC unknown to DHCS.		DHCS
D.0105	Service and Utilization Information	1.1.26	Within 30 calendar days of DHCS' request.		DHCS
D.0125	Litigation Support Records	1.1.27.A	Upon DHCS request.		DHCS
D.0107	DVBE Reporting Requirements	1.1.31	60 calendar days after receiving final payment, if Contractor made a commitment to achieve DVBE participation.		DHCS

EXHIBIT F, CONTRACTOR'S RELEASE

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0108	Contractor's Release	F	With the submission of final invoice(s).		DHCS

EXHIBIT G, BUSINESS ASSOCIATE ADDENDUM

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0109	Notice to DHCS of Breaches and Security Incidents	18.1.1	See contract language for details.		DHCS
D.0110	Completed Final Privacy Incident Reporting Form	18.3	Within ten Working Days of the discovery of the security incident or breach.		DHCS

EXHIBIT H, CONFLICT OF INTEREST AVOIDANCE REQUIREMENTS

No deliverables or requirements listed for this Exhibit.

EXHIBIT I, CONTRACTOR'S PARENT GUARANTY REQUIREMENTS

No deliverables or requirements listed for this Exhibit.

EXHIBIT J, DELEGATION REPORTING AND COMPLIANCE PLAN

No deliverables or requirements listed for this Exhibit.

EXHIBIT K, EXCLUDED PROVISIONS AS TO CONTRACTORS NOT LICENSED PURSUANT TO THE KNOX-KEENE HEALTH CARE SERVICE PLAN ACT OF 1975

No deliverables or requirements listed for this Exhibit.

EXHIBIT L, REQUIREMENTS SPECIFIC TO CONTRACTOR

Any deliverables for Contractor-specific requirements will be stated in Exhibit L.

Exhibit B – Budget Detail and Payment Provisions

1.0 Budget Detail and Payment Provisions

1.1 Budget Detail and Payment Provisions

1.1.1 Budget Contingency Clause
1.1.2 Contractor Risk
1.1.3 Capitation Payment
1.1.4 Capitation Payment Rates Constitute Payment in Full
1.1.5 Determination and Redetermination of Capitation Payment Rates
1.1.6 Redetermination of Capitation Payment Rates Due to Obligation Changes
1.1.7 Supplemental Payments
1.1.8 Additional Payments
1.1.9 Recovery of Amounts Paid to Contractor
1.1.10 Reinsurance
1.1.11 Catastrophic Coverage Limitation
1.1.12 Financial Performance Guarantee
1.1.13 Medicare Coordination
1.1.14 Special Contract Provisions Related to Payment
1.1.15 Medical Loss Ratio Remittance
1.1.16 State Program Receiving Federal Financial Participation
1.1.17 Community Reinvestment
1.1.18 Quality Achievement Requirement
1.1.19 Enhanced Care Management Risk Corridor
1.1.20 Federally Qualified Health Center Alternative Payment Model Risk Corridor
1.1.21 Transitional Rent Reconciliation

1.1 Budget Detail and Payment Provisions

1.1.1 Budget Contingency Clause

Any requirement of payment or performance by DHCS and Contractor for the period of the Contract will be dependent upon the availability of future appropriations by the Legislature for the purpose of the Medi-Cal program.

A. It is mutually agreed that if the Budget Act of the current year or any subsequent years covered under this Contract does not appropriate sufficient funds for the program, DHCS has no liability to pay any funds whatsoever to Contractor or to furnish any other considerations under this Contract, and Contractor is not obligated to perform any provisions of this Contract in any year when insufficient funding may occur. Further, should funding for any Fiscal Year be reduced or deleted by the Budget Act for purposes of this program, DHCS must have the option to:

   1) Cancel this Contract with no liability accruing to DHCS and no further obligation by Contractor to perform hereunder; or

   2) Offer a Contract amendment to Contractor to reflect the reduced amount of available funding.

B. All payments are subject to the availability of federal appropriation of Medicaid funding.

1.1.2 Contractor Risk

Except as otherwise specified in this Contract, Contractor will assume the total risk of providing Covered Services to Members on the basis of periodic Capitation Payments paid to Contractor by DHCS for each Member. Subject to Exhibit B, Section 1.1.15 (*Medical Loss Ratio Remittance*), any funds not expended by Contractor after having fulfilled all obligations under this Contract may be retained by Contractor.

1.1.3 Capitation Payment

A. DHCS must remit to Contractor a Capitation Payment no later than 45 calendar days after the first day of each month for each Member that appears on the approved list of Members supplied to Contractor by DHCS. Capitation Payments must be made in accordance with the schedule of Capitation Payment rates set forth in Exhibit L, Article 2.0 (*Capitation Payment Rates*). For the list of aid codes included in each Rate Group identified in Exhibit L, Article 2.0 (*Capitation Payment Rates*), please see the definition of Potential Member set forth in Exhibit L, Article 1.0 (*Definitions*). Supplemental and Additional Payments listed in Exhibit L,

Article 2.0 (*Capitation Payment Rates*) will be made in accordance to the requirements stated in Subsections 1.1.7 (*Supplemental Payments*) and 1.1.8 (*Additional Payments*) of this Exhibit.

B. If DHCS creates a new aid code that is split or derived from an existing aid code covered under this Contract, and the aid code has a neutral Contract Revenue effect for Contractor, then the split aid code will automatically be included in the same Rate Group as the original aid code covered under this Contract. Contractor agrees to accept the Capitation Payment rate specified for the original aid code as payment in full for Members in the new aid code. DHCS must confirm all aid code splits and the rates of payment for such new aid codes in writing to Contractor as soon as practicable after such aid code splits occur.

C. In accordance with 42 Code of Federal Regulations (CFR), part 438, section 438.7, the actuarial basis for the computation of Capitation Payment rates must be set forth in DHCS' rate certification(s) for the applicable Rating Period. Subject to approval by Centers for Medicare & Medicaid Services (CMS), said rate certification(s) are hereby incorporated by reference and made a part of this Contract by this reference as if attached hereto in full.

1.1.4 Capitation Payment Rates Constitute Payment in Full

Except as otherwise specified in this Contract, Capitation Payment rates for each Rating Period, as calculated by DHCS and approved by CMS, are prospective rates and constitute payment in full on behalf of a Member for all Covered Services required by such Member and for all Administrative Costs incurred by Contractor in providing or arranging for such services under the terms of this Contract. Except as otherwise specified in this Contract, DHCS is not responsible for making payments associated with Contractor's losses.

1.1.5 Determination and Redetermination of Capitation Payment Rates

A. In accordance with Welfare and Institutions Code (W&I) section 14301.1, DHCS must establish Capitation Payment rates on an actuarial basis for each Rating Period, and reserves the right to redetermine and to amend such rates as necessary and appropriate.

1) DHCS must establish Capitation Payment rates in accordance with W&I section 14301.1, applicable federal and State laws and regulations, and generally accepted actuarial principles and practices.

2) DHCS reserves the right, subject to actuarial judgment and generally accepted actuarial principles and practices, to consider

Contractor's performance on specified quality and equity benchmarks, as determined by DHCS and communicated to Contractors in advance of each applicable Rating Period, within the determination of Capitation Payment rates for that Rating Period.

3) If Contractor delegates financial risk for the provision of Covered Services in accordance with Exhibit A, Attachment III, Subsection 3.1.6 (*Financial Viability of Subcontractors, Downstream Subcontractors, and Network Providers*), DHCS reserves the right, subject to actuarial judgment and generally accepted actuarial principles and practices, to consider the actual payments received by Providers for providing Covered Services to Members to inform the determination of Capitation Payment rates

B. Capitation Payment rates must be effectuated through an amendment or change order to this Contract in accordance with Exhibit E, Subsection 1.1.6 (*Amendment and Change Order Process*) of this Contract, subject to the following provisions:

1) By accepting payment of new Capitation Payment rates prior to approval by CMS of the amendment/change order to this Contract implementing such new rates, Contractor stipulates to a confession of judgment for any and all amounts received in excess of the final approved rate. In the event that the final approved rate differs from the rates established by DHCS or agreed upon by Contractor and DHCS:

a) Any underpayment by DHCS must be paid to Contractor after final approval of the new rates. DHCS will provide Contractor a timeframe for payment of any underpayments;

b) Unless otherwise required by CMS, any overpayment to Contractor must be offset by DHCS' withholding from Contractor's future Contract Revenues of any amount due. DHCS may, at its sole discretion, withhold up to 100 percent of Contract Revenues for each month until any overpayment is fully recovered by the State; and

c) Contractor must review all Contract Revenues and notify DHCS of any payment errors in a form and manner specified by DHCS. If the error favors DHCS, DHCS may offset against future Contract Revenues as stated in paragraph (b) above. If the error favors Contractor, Contractor must notify DHCS within 365 calendar days of payment, otherwise Contractor forfeits the right to receive the corrected payment, except when Contractor demonstrates to DHCS' satisfaction,

in a form and manner specified by DHCS, that Contractor could not reasonably have identified the error.

2) If mutual agreement between DHCS and Contractor cannot be attained on Capitation Payment rates in accordance with this Paragraph B, Contractor has the right to terminate this Contract. Contractor's notification of the intent to terminate this Contract must be in writing and provided to DHCS at least nine months prior to the effective date of termination, subject to any earlier termination date negotiated in accordance with the terms set forth in Exhibit E, Subsection 1.1.16 (*Termination*) of this Contract. DHCS must pay Capitation Payment rates determined for the applicable Rating Periods until the Contract is terminated; and

3) DHCS must make reasonable efforts to notify and consult with Contractor regarding any proposed redetermination of Capitation Payment rates in accordance with this provision or Exhibit B, Subsection 1.1.6 (*Redetermination of Capitation Payment Rates Due to Obligation Changes*) below prior to implementation of any new rates.

1.1.6 Redetermination of Capitation Payment Rates Due to Obligation Changes

Final Capitation Payment rates may be adjusted during or subsequent to the applicable Rating Period to provide for changes in obligations that result in a material projected increase or decrease of cost as determined by the certifying actuaries, in accordance with W&I section 14301.1, to Contractor. Any adjustments must be effectuated through an amendment or change order to the Contract subject to the following:

A. The amendment or change order is effective as of the first day of the month in which the change in obligations is effective, as determined by DHCS;

B. In accordance with Subsection 1.1.5 *(Determination and Redetermination of Capitation Payment Rates*) of this Exhibit B, in the event DHCS is unable to process the amendment or change order in sufficient time to permit payment of the adjusted rates as of the month in which the change in obligations is effective, payment to Contractor must continue at the rates then in effect. Upon final approval of the amendment or change order, DHCS must make adjustments for those months in which interim payments were made; and

C. DHCS and Contractor may negotiate an earlier termination date, pursuant to Exhibit E, Subsection 1.1.16 (*Termination)* of this Contract, in the event a change in contractual obligations is created by a State or federal change

in the Medi-Cal program, or by a lawsuit that substantially alters the financial assumptions and conditions under which Contractor entered into this Contract, such that Contractor can demonstrate to the satisfaction of DHCS that it cannot remain financially solvent through the termination date provided by this Contract.

1.1.7 Supplemental Payments

A. Contractor is entitled to Supplemental Payments stated within this Section in accordance with the schedule of Supplemental Payment rates set forth in Exhibit L, Article 2.0 (*Capitation Payment Rates*). Contractor must maintain evidence of payment for qualified services entitling Contractor to Supplemental Payments. Upon audit, Contractor's failure to have supporting records may result in recoupment by DHCS of Supplemental Payments paid to Contractor.

1) On a monthly basis, by no later than 20 calendar days following the end of each month, and in a format specified by DHCS, Contractor must submit a report for Supplemental Payments. This report must identify the Members receiving services qualifying for a Supplemental Payment and for whom Contractor is claiming payment.

2) To be eligible to receive a Supplemental Payment, Contractor must properly submit all required data to DHCS within 12 months of the month of the service entitling Contractor to a Supplemental Payment.

B. **Maternity Supplemental Payments**

1) Contractor is entitled to receive maternity Supplemental Payments for Members enrolled with Contractor on the date of the delivery of a Child, including retroactive Enrollments.

2) The maternity Supplemental Payment reimburses Contractor for the projected cost of delivery as determined by DHCS.

1.1.8 Additional Payments

A. Contractor is entitled to additional payments stated within this Section in accordance with the schedule of additional payment rates set forth below. Contractor must maintain evidence of payment for qualified services entitling Contractor to additional payments. Upon audit, Contractor's failure to have supporting records may result in recoupment by DHCS of additional payments paid to Contractor.

1) On a monthly basis, by no later than 20 calendar days following the end of each month and in a format specified by DHCS, Contractor must submit a report for additional payments. This report must identify the Members receiving services qualifying for any additional payment and for whom Contractor is claiming payment.

2) To be eligible to receive an additional payment, Contractor must properly submit all required data to DHCS within 12 months of the month of the service entitling Contractor to an additional payment.

B. Indian Health Care Provider Payments

1) Contractor is entitled to receive an Indian Health Care Provider (IHCP) payment for Members qualified to receive services in accordance with Exhibit A, Attachment III, Subsection 3.3.7.C (*Indian Health Care Providers*) of this Contract.

2) DHCS will annually publish the IHCP payment rates via an All Plan Letter (APL).

3) The IHCP payment reimburses Contractor for the amount paid to the IHCPs as required in Exhibit A, Attachment III, Subsection 3.3.7 *(Federally Qualified Health Center, Rural Health Center, and Indian Health Care Provider)* of this Contract. Payments must be based on Member utilization of qualifying services at IHCPs as reported by Contractor.

C. Transitional Rent Payments

1) If Contractor elects to offer Transitional Rent to Members for dates of service from July 1, 2025, through December 31, 2025, and with DHCS establishing Transitional Rent as a mandatory benefit for dates of services from January 1, 2026 and forward, pursuant to Exhibit A, Attachment III, Section 4.5 (*Community Supports*), Contractor shall be entitled to receive Transitional Rent payments in a form and manner specified by DHCS through APL or other technical guidance for Members who receive Transitional Rent in accordance with Exhibit A, Attachment III, Subsection 4.5.3 (*Transitional Rent*) and APL or other guidance.

2) The Transitional Rent payment reimburses Contractor up to six months for each Member at an initial interim rate not to exceed the reimbursable ceiling set by DHCS, which will vary by location, setting, and size of unit, plus an administrative fee, pursuant to the Transitional Rent Payment Methodology, Transitional Rent Reimbursable Ceilings Fee Schedule, APL, or other technical

guidance. DHCS will perform an annual reconciliation process with Contractor as detailed in Exhibit B, Subsection 1.1.23 (*Transitional Rent Reconciliation*).

1.1.9 Recovery of Amounts Paid to Contractor

DHCS has the right to recover from Contractor amounts paid to Contractor in the following circumstances:

A. If DHCS determines that a Member has been improperly enrolled due to ineligibility of the Member to enroll in Contractor's Medi-Cal managed care health plan, a Member's residence is outside of Contractor's Service Area, or, pursuant to 22 California Code of Regulations (CCR) section 53891(a)(2), or a Member should have been disenrolled with an effective date in a prior month, DHCS may recover amounts paid to Contractor associated with the Member for the month(s) in question. To the extent permitted by law, Contractor may seek to recover any payments made to Providers for Covered Services rendered for the month(s) in question. Contractor must inform Providers that claims for services provided to Members during the month(s) in question may be paid by the DHCS fiscal intermediary if the Member is determined eligible for the Medi-Cal program;

B. Upon request by Contractor, DHCS may allow Contractor to retain amounts paid to Contractor associated with a Member who is eligible to enroll in Contractor's Medi-Cal managed care health plan, but should have been retroactively disenrolled in accordance with Exhibit A, Attachment III, Subsection 4.2.2 (*Disenrollment*) of this Contract or under other circumstances as approved by DHCS. If Contractor retains Capitation Payments, Supplemental Payments, and any other additional payments, Contractor must provide or arrange and pay for all Medically Necessary Covered Services for the Member until such Member is disenrolled on a non-retroactive basis pursuant to the terms set forth in Exhibit A, Attachment III, Subsection 4.2.2 (*Disenrollment*) of this Contract;

C. As a result of Contractor's failure to perform contractual responsibilities to comply with mandatory federal Medicaid requirements, the United States Department of Health and Human Services (U.S. DHHS) may disallow Federal Financial Participation (FFP) for payments made by DHCS to Contractor. In this event, DHCS may recover the amounts disallowed by U.S. DHHS and any state share associated with the claim by working directly with Contractor to recover the amount by either imposing an offset to Contract Revenues or requiring a check from Contractor. If recovery of the full amount at one time imposes a financial hardship on Contractor, Contractor may request to repay the recoverable amounts in monthly installments over a period of consecutive months not to exceed six

months. DHCS, at its sole discretion, may grant or deny such a request; and

D. If DHCS determines that any other erroneous or improper payment(s) not mentioned above has been made to Contractor, DHCS may recover all such determined amounts by the imposition of an offset to Contract Revenues. At least 30 calendar days prior to seeking any such recovery, DHCS must notify Contractor of the improper or erroneous nature of the payment, and must describe the recovery process. If recovery of the full amount at one time imposes a financial hardship on Contractor, Contractor may request to repay the recoverable amounts in monthly installments over a period of consecutive months not to exceed six months. DHCS, at its sole discretion, may grant or deny such a request.

E. Pursuant to Exhibit A, Attachment III, Subsection 1.3.6 *(Treatment of Overpayment Recoveries*)*,* if DHCS, CMS, DMFEA, federal or state departments of justice, or federal or state Inspectors General, or their agent or designee, identifies, whether through audit, investigation, or otherwise, that Contractor has made an overpayment (whether erroneous, improper, or otherwise) to any Subcontractors, Downstream Subcontractors, Network Providers, and/or Providers of Medi-Cal services, medical supplies, or drugs that Contractor has not previously identified and reported to DHCS within 30 calendar days of its identification to DHCS, DHCS will work directly with Contractor to either recover the entire amount of such overpayment by imposing an offset to Contract Revenues or require a check from Contractor.

1.1.10 Reinsurance

In accordance with 22 CCR section 53252, Contractor may obtain reinsurance (i.e., stop loss coverage) to ensure maintenance of adequate capital by Contractor for the cost of providing Covered Services under this Contract, subject to the following conditions:

A. Reinsurance must not reduce Contractor’s liability below $5,000 per Member for any one 12-month period.

B. Reinsurance may cover both of the following:

1) The total cost of services provided to Members under emergency circumstances by non-contracted Providers, including the cost of

inpatient care in a non-contracted facility until such time as the Member may be safely transported to a Network facility; and

2) Up to 90 percent of all expenditures related to this Contract exceeding 115 percent of Contract Revenues and third-party recoveries during any Fiscal Year of Contractor.

C. At its sole discretion and determination, and following consultation with Contractor, DHCS may require Contractor to retain appropriate reinsurance coverage for high-cost Members or services.

1.1.11 Catastrophic Coverage Limitation

DHCS may limit Contractor's liability to provide or arrange and pay for health care services for illness of, or injury to Members, resulting from or greatly aggravated by a catastrophic occurrence or disaster which occurs subsequent to Enrollment. Following the Director's invocation of this catastrophic coverage limitation, Contractor will return a prorated amount of the total Capitation Payment received by Contractor for the month. The amount returned will be determined by dividing the total Capitation Payment made to Contractor for such month by the number of days in that month, whereupon Contractor will return the amount to DHCS for each day in of the month after the Director’s invocation of this catastrophic coverage limitation.

1.1.12 Financial Performance Guarantee

A. In accordance with 22 CCR section 53865, Contractor must annually provide satisfactory evidence of, and maintain, a Financial Performance Guarantee in the form specified by DHCS and in an amount of at least one million dollars ($1,000,000) or equal to at least one month’s Contract Revenues for each of Contractor’s Service Areas, based on Contractor’s average monthly Contract Revenues calculated for the previous twelve months of Contractor’s operation, except that if Contractor has been operating for less than 12 months average monthly Contract Revenues will be calculated for as many months as Contractor has been operating, whichever is higher, and subject to approval by DHCS. In its discretion, DHCS may increase the required amount of the Financial Performance Guarantee for Contractor up to an amount of two million dollars ($2,000,000) or equal to two months’ Contract Revenues for each of Contractor’s Service Areas, based on Contractor’s average monthly Contract Revenues for the previous twelve months, except that if Contractor has been operating for less than 12 months, then the average monthly Contract Revenues will be calculated for as many months as Contractor has been operating, whichever is higher, for any material breach of this Contract.

B. At Contractor's request, and with DHCS approval, Contractor may establish a phase-in schedule to accumulate the required Financial Performance Guarantee. Contractor may elect to satisfy the Financial Performance Guarantee requirement by receiving payment on a post payment basis, subject to DHCS approval.

C. DHCS must take possession of the Financial Performance Guarantee in an amount sufficient to indemnify DHCS in the event that Contractor materially breaches or defaults on one or more terms in this Contract. Unless DHCS has a financial claim or offset against Contractor in which case DHCS may immediately enforce its rights under the Financial Performance Guarantee, the Financial Performance Guarantee must remain in effect through the completion of the Phaseout Period in accordance with Exhibit E, Subsection 1.1.17 (*Phaseout Requirements*).

1.1.13 Medicare Coordination

In accordance with 42 CFR section 438.3(t), Contractor must enter into a Coordination of Benefits Agreement with the Medicare program through CMS, and must agree to participate in Medicare’s automated claims crossover process for full benefit dual eligible Members.

1.1.14 Special Contract Provisions Related to Payment

A. Contractor must reimburse Network Providers pursuant to the terms of each of the following applicable Pass-Through Payments established pursuant to 42 CFR section 438.6(d), in accordance with the CMS-approved rate certification, and in a form and manner specified by DHCS through APLs or other technical guidance:

1) Private Hospital Pass-Through Payment, which requires Contractor to make increased payments to private hospitals in accordance with DHCS guidance.

2) Martin Luther King, Jr. (MLK) Community Hospital Pass-Through Payment, which requires Contractor to make increased payments

to MLK Community Hospital in Los Angeles County in accordance with W&I section 14165.50 and DHCS guidance.

3) Benioff Children's Hospital Oakland (BCHO) Pass-Through Payment, which requires Contractor to make increased payments to BCHO in Alameda County in accordance with DHCS guidance.

4) Distinct Part Nursing Facilities Pass-Through Payment, which requires Contractor to make increased payments to select publicly owned hospitals in accordance with DHCS guidance.

B. Contractor must reimburse Providers pursuant to the terms of each applicable Directed Payment Initiative in a form and manner specified by DHCS through APLs or other technical guidance. For applicable Rating Periods, DHCS will make the terms of each Directed Payment Initiative, including the Directed Payment Initiative preprint as applicable, available on the DHCS website at https://www.dhcs.ca.gov/services/Pages/DirectedPymts.aspx.

Directed Payment Initiatives are subject to change and currently include:

1) Designated Public Hospital (DPH) Enhanced Payment Program (EPP), which requires Contractor to make uniform dollar or percentage increase payments to DPH systems for every qualifying service or assigned Member months in accordance with DHCS guidance (including but not limited to APL 21-018), the Directed Payment Initiative preprint, and W&I section 14197.4(b).

Additional details regarding this payment arrangement are as follows:

a. Rate Certification Name: Enhanced Payment Program;

b. State's managed care contract Rating Period: January 1, 2025 – December 31, 2025;

c. Provider class participating in payment arrangement: Designated public hospitals as defined in W&I section 14184.10(f);

d. Description of how the payment arrangement is directed:

For each class of Providers, DHCS will establish two pools from which the uniform increases to payments for that

Provider class will be made. The two pools will consist of total amounts for:

i. Uniform percent increases to payments for capitated contractual arrangements for classes of DPHs that are reimbursed primarily on a capitated basis; and

ii. Uniform dollar amount payments for FFS contractual arrangements for all classes of DPHs, separately for contracted inpatient hospital services including hospital-based Long-Term Care services, and contracted non-inpatient services including outpatient hospital, emergency department, and non-facility professional services.

A weighted pro rata redistribution of a particular pool shall be used to distribute that pool based on actual member months or actual contracted utilization (as adjusted for the acuity of services provided), as applicable.

2) Private Hospital Directed Payments Program (PHDP), which requires Contractor to make uniform dollar increase payments to eligible private hospitals for every qualifying service in accordance with DHCS guidance (including but not limited to APL 21-018), and the Directed Payment Initiative preprint.

Additional details regarding this payment arrangement are as follows:

a. Rate Certification Name: Private Hospital Directed Payment Uniform Dollar Increase;

b. State's managed care contract Rating Period: January 1, 2025 - December 31, 2025;

c. Provider class participating in payment arrangement: Private hospitals as defined in W&I section 14169.51(ap) except those also classified as a new hospital according to W&I section 14169.51(ai);

d. Description of how the payment arrangement is directed:

For each Provider class, DHCS will establish two pools from which the total uniform increment payments for each

Provider class will be made. The two pools will consist of total amounts for:

i. Contracted inpatient services; and

ii. Select contracted non-inpatient services.

A weighted pro rata redistribution of a particular pool shall be used to distribute that pool based on actual contracted utilization (as adjusted for the acuity of services provided).

3) District Hospital Directed Payments Program (DHDP), which requires Contractor to make uniform dollar increase payments to eligible District and Municipal Public Hospitals (DMPHs) for every qualifying service in accordance with DHCS guidance (including but not limited to APL 21-018), and the Directed Payment Initiative preprint.

Additional details regarding this payment arrangement are as follows:

a. Rate Certification Name: District and Municipal Public Hospital Directed Payment Uniform Dollar Increase;

b. State's managed care contract Rating Period: January 1, 2025 - December 31, 2025;

c. Provider class participating in payment arrangement: District hospitals and municipal public hospitals that are non-

designated public hospitals as defined in W&I section 14166.1(f);

d. Description of how the payment arrangement is directed:

DHCS will establish two pools from which the total uniform increment payments for each Provider class will be made. The two pools will consist of total amounts for:

i. Contracted inpatient services; and

ii. Select contracted non-inpatient services.

A weighted pro rata redistribution of a particular pool shall be used to distribute that pool based on actual contracted utilization (as adjusted for the acuity of services provided).

4) DPH Quality Incentive Pool (QIP), which requires Contractor to make performance-based quality incentive payments to DPH systems based on DHCS' evaluation of DPH systems' performance on specified quality measures in accordance with DHCS guidance (including but not limited to APL 21-018), the Directed Payment Initiative preprint, and W&I section 14197.4(c).

Additional details regarding this payment arrangement are as follows:

a. Rate Certification Name: Designated Public Hospital Quality Incentive Pool;

b. State's managed care contract Rating Period: January 1, 2025 - December 31, 2025;

c. Provider class participating in payment arrangement: Designated public hospitals as defined in W&I section 14184.10(f);

d. Description of how the payment arrangement is directed:

i. Payments will be made to DPH systems for meeting designated performance measures that are linked to

the utilization and delivery of services under the managed care plan contracts.

ii. Performance standards will be applied equally within the class.

5) DMPH QIP, which requires Contractor to make performance-based quality incentive payments to DMPH systems based on DHCS' evaluation of DMPH systems' performance on specified quality measures in accordance with DHCS guidance (including but not limited to APL 21-018), the Directed Payment Initiative preprint, and W&I section 14197.4(c).

Additional details regarding this payment arrangement are as follows:

a. Rate Certification Name: District and Municipal Public Hospital Quality Incentive Pool;

b. State's managed care contract Rating Period: January 1, 2025 - December 31, 2025;

c. Provider class participating in payment arrangement: District and municipal public hospitals that are non-designated public hospitals as defined W&I section 14166.1(f);

d. Description of how the payment arrangement is directed:

i. Payments will be made to DMPH systems for meeting designated performance measures that are linked to the utilization and delivery of services under the managed care plan contracts.

ii. Performance standards will be applied equally within the class.

6) Directed Payments for Developmental Screening Services, which requires Contractor to make uniform dollar increase payments to eligible Network Providers for every adjudicated claim for specified developmental screening services in accordance with DHCS

guidance (including but not limited to APL 23-016), the Directed Payment Initiative preprint, and W&I section 14105.197(a)(3).

Additional details regarding this payment arrangement are as follows:

a. Rate Certification Name: Developmental Screening;

b. State's managed care contract Rating Period: January 1, 2025 – December 31, 2025;

c. Provider class participating in payment arrangement: All eligible Network Providers for every adjudicated claim for qualifying developmental screening services;

d. Description of how the payment arrangement is directed:

i. DHCS directs managed care plans to make uniform and fixed dollar amount add-on payments for qualifying developmental screening services to eligible Network Providers based on the utilization and delivery of services for eligible Members.

ii. These directed payments will be implemented for certain managed care categories of aid.

iii. Subsets of Members or categories of aid may be excluded from the enhanced contracted payment arrangement as necessary for actuarial or other reasons.

7) Directed Payments for Adverse Childhood Experiences (ACEs), which requires Contractor to pay eligible Network Providers at no less than the California Medicaid State Plan approved rates for every adjudicated claim for specified ACEs screening services in

accordance with DHCS guidance (including but not limited to APL or other guidance), and W&I section 14105.197(a)(4).

Additional details regarding this payment arrangement are as follows:

a. Rate Certification Name: Adverse Childhood Experiences Screening;

b. State's managed care contract Rating Period: January 1, 2025 – December 31, 2025;

c. Provider class participating in payment arrangement: All eligible Network Providers based on the utilization and delivery of services for eligible Members;

d. Description of how the payment arrangement is directed:

DHCS directs managed care plans to pay no less than the California Medicaid State Plan approved rates for specific ACEs services.

8) Proposition 56 Directed Payments for Family Planning Services, which requires Contractor to make uniform dollar increase payments to eligible Providers for every adjudicated claim for specified family planning services in accordance with DHCS guidance (including but not limited to APL or other guidance), and the Directed Payment Initiative preprint.

Additional details regarding this payment arrangement are as follows:

a. Rate Certification Name: Prop 56 Family Planning;

b. State's managed care contract Rating Period: January 1, 2025 – December 31, 2025;

c. Provider class participating in payment arrangement: All eligible contracted and non-contracted Providers for every adjudicated claim for select family planning services;

d. Description of how the payment arrangement is directed:

i. Managed care plans will make uniform and fixed dollar amount add-on payments for select family planning services to eligible contracted and non-

contracted Providers based on the utilization and delivery of services for eligible Members.

ii. These directed payments will be implemented for certain managed care categories of aid.

iii. Subsets of Members or categories of aid may be excluded from the enhanced contracted payment arrangement as necessary for actuarial or other reasons.

9) Organ and Bone Marrow Transplants, which requires Contractor to pay eligible contracted and non-contracted Providers amounts equivalent to the California Medicaid State Plan approved rates, or amounts equivalent to the rates published by DHCS for University of California system facilities furnishing subject services, for specified organ and bone marrow transplant services using the methodology developed and published by DHCS on an annual basis in accordance with DHCS guidance (including but not limited to APL or other guidance), the Directed Payment Initiative preprint, and W&I section 14184.201(d).

Additional details regarding this payment arrangement are as follows:

a. Rate Certification Name: Major Organ Transplant Hospital Directed Payment;

b. State's managed care contract Rating Period: January 1, 2025 – December 31, 2025;

c. Provider class participating in payment arrangement: All Network and non-Network Providers qualified to provide organ and bone marrow transplant surgeries: 1) DPHs as defined in W&I section 14184.101(f) and 2) Private hospitals and DMPHs, meaning a hospital that is not a DPH;

d. Description of how the payment arrangement is directed:

DHCS directs managed care plans to reimburse providers of organ or bone marrow transplants, within each class of Providers, at levels equivalent to what they would have received in the Medi-Cal FFS delivery system.

10) LTC FFS-Equivalent Base Directed Payment, which requires Contractors to pay Network Providers, in specified counties where

services were traditionally covered in the FFS delivery system, at exactly the California Medicaid State Plan approved case or service rates for Skilled Nursing Facility (SNF) services and Intermediate Care Facility for the Developmentally Disabled (ICF/DD), ICF/DD-Habilitative (ICF/DD-H), and ICF/DD-Nursing (ICF/DD-N) services and Subacute (adult and pediatric) services. In all other counties, it requires Contractor to pay Network Providers at no less than the California Medicaid State Plan approved rates for SNF services and ICF/DD, ICF/DD-H, and ICF/DD-N services and Subacute (adult and pediatric) services at minimum. All payments must be made in accordance with DHCS guidance (including but not limited to APL 24-009), the Directed Payment Initiative preprint, and W&I section 14184.201(b) – (c).

Additional details regarding this payment arrangement are as follows:

a. Rate Certification Name: Long-Term Care Directed Payment;

b. State's managed care contract Rating Period: January 1, 2023 – December 31, 2025;

c. Provider class participating in payment arrangement: All Network Providers of SNF services, including custodial and skilled care, starting January 1, 2023, and other institutional LTC services starting January 1, 2024, serving Members enrolled in managed care plans operating in: 1) "transitioning" counties or 2) "non-transitioning" counties;

d. Description of how the payment arrangement is directed:

    i. All eligible Network Providers of LTC services in "transitioning" counties will be reimbursed for applicable services at the exact rate established in accordance with the methodology outlined in Supplement 4 of Attachment 4.19-D of the California Medicaid State Plan.

    ii. All eligible Network Providers of LTC services in "non-transitioning" counties will be reimbursed for applicable services at no less than the exact rate established in accordance with the methodology

outlined in Supplement 4 of Attachment 4.19-D of the California Medicaid State Plan.

11) Workforce Quality Incentive Program (WQIP), which requires Contractor to make uniform dollar increase payments to eligible Network Providers for every qualifying service adjusted based on DHCS' evaluation of their performance on specified quality and workforce measures in accordance with DHCS guidance (including but not limited to APLs or other guidance), the Directed Payment Initiative preprint, and W&I section 14126.024.

Additional details regarding this payment arrangement are as follows:

a. Rate Certification Name: Skilled Nursing Facility and Workforce and Quality Incentive Program;

b. State’s managed care contract Rating Period: January 1, 2025 - December 31, 2025;

c. Provider class participating in payment arrangement: Freestanding SNFs, including adult subacute units, as defined in W&I section 14126.024(l);

d. Description of how the payment arrangement is directed:

DHCS directs managed care plans to make uniform, fixed-dollar add-on payments for qualifying contracted SNF days based on the utilization and delivery of services for Medi-Cal managed care Members.

Payments will be in the form of a uniform per-diem increase for qualifying SNF services that is adjusted based on facility-specific performance on designated quality metrics following a uniform quality adjustment methodology across all eligible Network SNFs.

12) Equity and Practice Transformation Provider Directed Payment Program, which requires Contractor to pay performance-based quality incentive payments to Primary Care practices that provide pediatric, family medicine, internal medicine, or obstetrics and gynecology (OB/GYN) services Members based on DHCS' evaluation of Provider performance on specified quality measures in accordance with the Directed Payment Initiative preprint and in a

form and manner specified by DHCS through APLs or other guidance.

Additional details regarding this payment arrangement are as follows:

a. Rate Certification Name: Equity and Practice Transformation Directed Payment;

b. State's managed care contract Rating Period: January 1, 2024 – December 31, 2026;

c. Provider class participating in payment arrangement: Pediatric, family practice, adult medicine Primary Care, Primary Care OB/GYN, and Behavioral Health Providers in Primary Care settings selected through the designated application process;

d. Description of how the payment arrangement is directed:

   i. DHCS directs managed care plans to make uniform, fixed-dollar add-on payments for each assigned Medi-Cal managed care Member at the time of application.

   ii. Uniform dollar increase payments will be subject to a tiered methodology based on milestones.

   iii. Each Provider will be placed into a designated tier, which will correspond to a specified percentage (ranging from 0 percent to 100 percent) of the uniform dollar add-on amounts applicable to that class of Providers.

   iv. All eligible Network Providers participating will be measured on the same milestones and scoring criteria for their selected milestones.

13) Targeted Rate Increases require Contractor to pay eligible Network Providers at no less than the California Medicaid State Plan approved rates for specified primary care services, including those provided by physician and non-physician professionals, obstetric services, including Doula services, and Non-Specialty Mental Health Services, in accordance with W&I section 14105.201, and in a form and manner specified by DHCS through APL 24-007 or other guidance. Within the Targeted Rate Increases fee schedule, in accordance with W&I section 5961.4(c), and for applicable dates

of service, Contractor must reimburse Providers of Medically Necessary outpatient mental health or SUD treatment provided at a School Site to a Member who is a student 25 years of age or younger at least at the fee schedule rate or rates developed by the Department in accordance with W&I section 5961.4(a), as defined by DHCS in the California Medicaid State Plan and applicable DHCS guidance, but only to the extent Contractor is financially responsible for those School Site services under this Contract.

Additional details regarding this payment arrangement are as follows:

a. Rate Certification Name: Targeted Provider Rate Increase;

b. State's managed care contract Rating Period: January 1, 2025 - December 31, 2025;

c. Provider class participating in payment arrangement: Physician, non-physician professional, and obstetric services;

d. Description of how the payment arrangement is directed:

For a Member receiving an eligible service from an eligible Network Provider, the managed care plan must ensure that payment is, at minimum, made at or equivalent to the posted TRI fee schedule rate.

14) Children's Hospital Supplemental Payment (CHSP), which requires Contractor to make uniform dollar increase payments to Children's Hospitals, as defined in W&I section 10727, for each qualifying

service in accordance with DHCS guidance (including but not limited to APL 21-018), and the Directed Payment Initiative preprint.

Additional details regarding this payment arrangement are as follows:

a. Rate Certification Name: Children's Hospital Supplemental Payment;

b. State's managed care contract Rating Period: January 1, 2025 - December 31, 2025;

c. Provider class participating in payment arrangement: Children's hospitals as defined in W&I section 10727;

d. Description of how the payment arrangement is directed:

i. For each Provider class, DHCS will establish two pools from which the total uniform increment payments for each Provider class will be made. The two pools will consist of total amounts for:

a. Contracted Inpatient services; and;

b. Select contracted non-inpatient services.

ii. A weighted pro rata redistribution of a particular pool shall be used to distribute that pool based on actual contracted utilization (as adjusted for the acuity of services provided).

15) Federally Qualified Health Center (FQHC) Alternative Payment Methodology (APM), which requires Contractor to make capitated payments to participating FQHCs for each Member assigned to that FQHC, in accordance with W&I, Article 4.1 (commencing with Section 14138.1) of Chapter 7 of Part 3 of Division 9, and Attachment 4.19-B, pages 6AA7-6AA17, of the California Medicaid

State Plan, and direction provided by DHCS through APLs or other guidance.

Additional details regarding this payment arrangement are as follows:

a. Rate Certification Name: Federally Qualified Health Centers Alternative Payment Model;

b. State's managed care contract Rating Period: January 1, 2025 - December 31, 2025;

c. Provider class participating in payment arrangement: FQHCs accepted through the application process;

d. Description of how the payment arrangement is directed:

Each managed care plan with Members assigned to a participating FQHC will pay a monthly FQHC APM Per Member Per Month (PMPM) rate.

16) Community Clinic Directed Payment (CCDP), which requires Contractor to make performance-based increased payments to eligible Community Clinics for unique daily qualifying services in accordance with W&I section 14105.467 and DHCS guidance

(including but not limited to APL 25-015), and the Directed Payment Initiative preprint.

Additional details regarding this payment arrangement are as follows:

a. Rate Certification Name: Community Clinics Directed Payments;

b. State's managed care contract Rating Period: January 1, 2025 - December 31, 2025;

c. Provider class participating in payment arrangement: Non-hospital 340B community clinics that have applied and been accepted into the program;

d. Description of how the payment arrangement is directed:

DHCS directs Medi-Cal managed care plans to pay eligible Network Providers a per-visit add-on rate for qualifying unique daily Primary and specialty care physician services. The add-on amount will be calculated for CY 2025 by dividing the targeted program amount ($205 million) by the projected number of qualifying contracted visits and adjusted based on each eligible Provider's performance on quality metrics.

17) Proposition 35 Directed Payment for Emergency Department Physician Services, which requires the Contractor to make uniform dollar increase payments to eligible Providers for every adjudicated claim for specified emergency physician services in accordance with DHCS guidance (including but not limited to APL or other

guidance), the Directed Payment Initiative preprint, and W&I section 14199.100 et. seq.

Additional details regarding this payment arrangement are as follows:

a. Rate Certification Name: Prop 35 ED Physicians Directed Payment;

b. State's managed care contract Rating Period: January 1, 2025 – December 31, 2025;

c. Provider class participating in payment arrangement: All eligible contracted and non-contracted Providers for every adjudicated claim for select emergency facility services;

d. Description of how the payment arrangement is directed:

i. Managed care plans will make uniform and fixed dollar amount add-on payments for select emergency physician services to eligible contracted and non-contracted Providers based on the utilization and delivery of services for eligible Members.

ii. These directed payments will be implemented for certain managed care categories of aid.

iii. Subsets of Members or categories of aid may be excluded from the enhanced contracted payment arrangement as necessary for actuarial or other reasons.

C. Contractor must comply with the terms of any Risk Sharing Mechanisms instituted in accordance with 42 CFR section 438.6(b)(1), in a form and manner specified by DHCS through APLs or other technical guidance.

D. Contractor must comply with the terms of any applicable Incentive Arrangements approved by CMS under 42 CFR section 438.6(b)(2), in a form and manner specified by DHCS through APLs or other technical guidance. For applicable Rating Periods, DHCS will make the terms of each approved Incentive Arrangement available on the DHCS website. Incentive Arrangement payments must not exceed 105 percent of the approved Capitation Payments attributable to the Enrollees or services covered by the Incentive Arrangement, as specified in 42 CFR section 438.6(b)(2) and as calculated by DHCS. DHCS may impose a cap on incentive payments and/or participation in applicable Incentive

Arrangements if DHCS determines that the incentive payment(s) are likely to exceed 105 percent of the approved Capitation Payments. Contractor will be required to remit to DHCS any incentive payment amounts in excess of 105 percent of approved Capitation Payments. Incentive Arrangements are subject to change in accordance with the requirements of 42 CFR section 438.6(b)(2). Current Incentive Arrangement includes:

The Quality Withhold and Incentive Program, which consists of a Withhold Arrangement as described in Paragraph E below, and an Incentive Arrangement through which Contractor may earn incentive payments for achievement of certain targets associated with quality scoring from Healthcare Effectiveness Data and Information Set (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) related data, as determined by DHCS and in accordance with the terms on the DHCS website, W&I section 14301.1(e) and (o)(4), and in a form and manner specified through APLs or other guidance.

E. Contractor must comply with the terms of any applicable Withhold Arrangement approved by CMS under 42 CFR section 438.6(b)(3), in a form and manner specified by DHCS through APLs or other guidance. For applicable Rating Periods, DHCS will make the terms of each approved Withhold Arrangement available on the DHCS website.

1) The Withhold Arrangement must ensure that the Capitation Payment, minus any portion of the withhold that is not reasonably achievable, is actuarially sound as determined by an actuary. The total amount of the withhold, achievable or not, will take into consideration the financial operating needs accounting for the size and characteristics of the populations covered under this Contract, as well as Contractor's capital reserves as measured by the risk-based capital level, months of claims reserve, or other appropriate measure of reserves.

2) Current Withhold Arrangements include the Quality Withhold and Incentive Program, which consists of an Incentive Arrangement as described in Paragraph D, and a Withhold Arrangement through which Contractor may earn back the entire Capitation Payment withheld, or portion thereof, for achievement of certain targets associated with quality scoring from HEDIS® and CAHPS® related data, as determined by DHCS and in accordance with DHCS guidance, including but not limited to the terms on the DHCS website, W&I section 14301.1(e) and (o)(4), and in a form and manner specified in APLs or other guidance.

1.1.15 Medical Loss Ratio Remittance

In accordance with W&I section 14197.2(c)(1), Contractor must provide a remittance to DHCS for a Medical Loss Ratio (MLR) reporting year if the MLR reported in accordance with Exhibit A, Attachment III, Subsection 1.2.5 (*Medical Loss Ratio*) for that MLR reporting year does not meet the minimum MLR standard of 85 percent. DHCS must validate Contractor's reported remittance amount pursuant to Exhibit A, Attachment III, Subsection 1.2.5 (*Medical Loss Ratio*) and determine the final remittance amount owed by Contractor for each MLR reporting year and rating region. Starting January 1, 2025, Contractor must impose equivalent remittance requirements on its Fully Delegated Subcontractors, Partially Delegated Subcontractors, Downstream Fully Delegated Subcontractors, and Downstream Partially Delegated Subcontractors.

1.1.16 State Program Receiving Federal Financial Participation

Should any part of the scope of work under this contract relate to a State program receiving Federal Financial Participation (FFP) that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), Contractor must cease its work on the part no longer authorized by law after the effective date of the loss of such program authority. DHCS must adjust Capitation Payments to remove costs that are specific to any State program or activity receiving FFP that is no longer authorized by law to receive FFP. If Contractor works on a State program or activity receiving FFP that is no longer authorized by law after the date the legal authority for the work ends, Contractor will not be paid for that work. If DHCS has paid Contractor in advance to work on a no-longer-authorized State program or activity receiving FFP and under the terms of this contract the work was to be performed after the date the legal authority ended, the payment for that work should be returned to DHCS. However, if Contractor worked on a State program or activity receiving FFP prior to the date legal authority ended for that State program or activity receiving FFP, and DHCS included the cost of performing that work in its payments to Contractor, Contractor may keep the payment for that work even if the payment was made after the date the State program or activity receiving FFP lost legal authority.

1.1.17 Community Reinvestment

A. Contractor must demonstrate a commitment to the local communities in which it operates through community reinvestment activities including contributing a set percentage of its annual net income under this Contract to community reinvestment, in accordance with the plan developed pursuant to Exhibit A, Attachment III, Subsection 1.2.7 (*Community Reinvestment Plan and Report*). The percentage of Contractor's annual net income required to be contributed must be:

1) 5 percent of the portion of Contractor's annual net income that is less than or equal to 7.5 percent of Contract Revenues for the year; and

2) 7.5 percent of the portion of Contractor's annual net income that is greater than 7.5 percent of Contract Revenues for the year.

B. If Contractor has a Subcontractor that meets community reinvestment requirements based on criteria established by DHCS through APLs or similar guidance, Contractor must require the applicable Subcontractor to demonstrate a commitment to the local communities in which it operates through community reinvestment activities including contributing a set percentage of the applicable Subcontractor's annual net income under the Subcontractor Agreement that is attributable to Members covered under this Contract to community reinvestment, in accordance with the plan developed pursuant to Exhibit A, Attachment III, Subsection 1.2.7 (*Community Reinvestment Plan and Report*). The percentage of the applicable Subcontractor's annual net income required to be contributed must be:

1) 5 percent of the portion of the applicable Subcontractor's annual net income that is less than or equal to 7.5 percent of the amount the Subcontractor is paid under its Subcontractor Agreement with Contractor for the year; and

2) 7.5 percent of the portion of the applicable Subcontractor's annual net income that is greater than 7.5 percent of the amount the Subcontractor is paid under its Subcontractor Agreement with Contractor for the year.

1.1.18 Quality Achievement Requirement

If Contractor does not meet quality outcome metrics as defined through an APL or similar guidance, it must contribute an additional 7.5 percent of its annual net income under this Contract to community reinvestment in accordance with the plan developed pursuant to Exhibit A, Attachment III, Subsection 1.2.7 (*Community Reinvestment Plan and Report*).

1.1.19 Enhanced Care Management Risk Corridor

A Risk Sharing Mechanism will be in effect for each of the Rating Periods covering dates of services from January 1, 2022, through December 31, 2025.

A. The Risk Sharing Mechanism described in this provision may result in payment by the State to Contractor or by Contractor to the State in a form and manner specified by DHCS through APLs or other technical guidance.

B. The Risk Sharing Mechanism will be symmetrical and based on the results of an Enhanced Care Management (ECM) risk corridor calculation performed in a form and manner specified by DHCS through APLs or other technical guidance, aggregated across applicable Medi-Cal Managed Care contracts between Contractor and the State for those capitation increments, services, and populations associated with ECM, as determined by DHCS.

C. Contractor must provide and certify allowable medical expense data as necessary for the ECM risk corridor calculation in a form and manner specified by DHCS. The data and any related substantiating documentation may be subject to review and adjustment at DHCS' discretion in a form and manner specified by DHCS through APLs or other technical guidance, and may be subject to audit by the State or its designee.

D. DHCS or its designee will initiate the ECM Risk Corridor calculation for a given Rating Period no sooner than 12 months after the end of the applicable Rating Period.

E. Contractor must comply with the terms of any Risk Sharing Mechanisms instituted in accordance with 42 CFR section 438.6(b)(1), in a form and manner specified by DHCS through APLs or other technical guidance.

1.1.20 Federally Qualified Health Center Alternative Payment Model Risk Corridor

A Risk Sharing Mechanism will be in effect for each of the Rating Periods that the Federally Qualified Health Center (FQHC) Alternative Payment Model (APM) is in effect in accordance with W&I section 14138.16.

A. The Risk Sharing Mechanism described in this Subsection may result in payment by the State to Contractor or by Contractor to the State in a form and manner specified by DHCS through APLs or other technical guidance.

B. The Risk Sharing Mechanism will be symmetrical and based on the results of an FQHC APM risk corridor calculation performed in a form and manner specified by DHCS through APLs or other technical guidance, aggregated across applicable Medi-Cal managed care contracts between Contractor and the State for those capitation increments, services, and populations associated with the FQHC APM, as determined by DHCS.

C. Contractor must provide and certify allowable medical expense data as necessary for the FQHC APM risk corridor calculation in a form and manner specified by DHCS. The data and any related substantiating documentation may be subject to review and adjustment at DHCS' discretion in a form and manner specified by DHCS through APLs or other

technical guidance, and may be subject to audit by the State or its designee.

D. DHCS or its designee will initiate the FQHC APM Risk Corridor calculation for a given Rating Period no sooner than 12 months after the end of the applicable Rating Period.

E. Contractor must comply with the requirements set forth in Exhibit B, Subsection 1.1.14(C) (*Special Contract Provisions Related to Payment*).

1.1.21 Transitional Rent Reconciliation

A non-risk reconciliation will be in effect if Contractor elects to offer Transitional Rent to Members as an optional benefit for dates of service from July 1, 2025, through December 31, 2025, and with DHCS establishing Transitional Rent as a mandatory benefit for dates of service from January 1, 2026 and forward, pursuant to Exhibit A, Attachment III, Section 4.5 (*Community Supports*).

A. DHCS will reconcile the sum of the initial interim payments made pursuant to Exhibit B, Subsection 1.1.8(C) (*Additional Payments*) to the lesser of:

1) The aggregated cost of rent or temporary housing provided by Contractor in accordance with Exhibit A, Attachment III, Subsection 4.5.3 (*Transitional Rent*); or

2) The aggregated applicable reimbursable ceilings for rent or temporary housing provided by Contractor in accordance with Exhibit A, Attachment III, Subsection 4.5.3 (*Transitional Rent*). Any costs incurred by the Contractor that exceed the aggregate ceiling will remain the financial responsibility of the Contractor and will not be reimbursed under the non-risk arrangement.

B. Administrative fee payments made pursuant to Exhibit B, Subsection 1.1.8(C) (*Additional Payments*) will not be reconciled.

The reconciliation described in this Subsection may result in payment by DHCS to Contractor or by Contractor to DHCS in a form and manner specified by DHCS through APLs or other technical guidance. Contractor may not retain any portion of the reconciled payment received from DHCS for the cost of rent or temporary housing.

C. The reconciliation will be based on the results of a Transitional Rent reconciliation calculation performed in a form and manner specified by DHCS through APLs or other technical guidance, aggregated across applicable Medi-Cal managed care contracts between Contractor and the State for those payments, services, and populations associated with the provision of Transitional Rent services, as determined by DHCS.

D. Contractor must provide and certify allowable Transitional Rent data as necessary for the Transitional Rent reconciliation calculation in a form and manner specified by DHCS through APLs or other technical guidance, and may be subject to audit by the State or its designee.

E. DHCS or its designee will initiate the Transitional Rent reconciliation calculation for a given Rating Period no sooner than 12 months after the end of the applicable Rating Period

Exhibit C – General Terms and Conditions

The entire General Terms and Conditions (GTC 04/2017) developed by the California Department of General Services (DGS) (“Exhibit C”) is not included in this Contract. Instead, applicable terms and provisions from Exhibit C have been incorporated throughout this Contract.

In the event that DGS amends Exhibit C after the effective date of the Contract, Contractor agrees that DHCS, in its sole discretion, may incorporate future DGS amendments into this Contract through the issuance of an All Plan Letter (APL) or other similar instructions.

Exhibit D(f) – Special Terms and Conditions

This is version (Rev. 10/22)

Exhibit D(f)

Special Terms and Conditions

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

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

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

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

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

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1. Federal Equal Opportunity Requirements

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

a. The Contractor will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. The Contractor will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. The Contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973 and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212). Such notices state the Contractor's obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

b. The Contractor will, in all solicitations or advancements for employees placed by or on behalf of the Contractor, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.

c. The Contractor will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of the Contractor's commitments under the provisions herein and post copies of the notice in conspicuous places available to employees and applicants for employment.

d. The Contractor will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, ‘Amending Executive Order 11246 Relating to Equal Employment Opportunity,‘ and as supplemented by regulation at 41 CFR part 60, “Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor,” and of the rules, regulations, and relevant orders of the Secretary of Labor.

e. The Contractor will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

f. In the event of the Contractor's noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this Agreement may be cancelled, terminated, or suspended in whole or in part and the Contractor may be declared ineligible for further federal and State contracts in accordance with procedures authorized in Federal Executive Order No. 11246 as amended and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

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

2. Travel and Per Diem Reimbursement

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

Reimbursement for travel and per diem expenses from DHCS under this Agreement shall, unless otherwise specified in this Agreement, be at the rates currently in effect, as established by the California Department of Human Resources (CalHR), for nonrepresented State employees as stipulated in DHCS' Travel Reimbursement

Information Exhibit. If the CalHR rates change during the term of the Agreement, the new rates apply upon their effective date and no amendment to this Agreement shall be necessary. Exceptions to CalHR rates may be approved by DHCS upon the submission of a statement by the Contractor indicating that such rates are not available to the Contractor. No travel outside the State of California shall be reimbursed without prior authorization from DHCS. Verbal authorization should be confirmed in writing. Written authorization may be in a form including fax or email confirmation.

3. Procurement Rules

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

a. Equipment/Property definitions

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

(1) **Major equipment/property**: A tangible or intangible item having a base unit cost of $5,000 or more with a life expectancy of one (1) year or more and is either furnished by DHCS or the cost is reimbursed through this Agreement. Software and videos are examples of intangible items that meet this definition.

(2) **Minor equipment/property:** A tangible item having a base unit cost of less than $5,000 with a life expectancy of one (1) year or more and is either furnished by DHCS or the cost is reimbursed through this Agreement.

b. Government and public entities (including State colleges/universities and auxiliary organizations), whether acting as a contractor and/or subcontractor, may secure all commodities, supplies, equipment and services related to such purchases that are required in performance of this Agreement. Said procurements are subject to Paragraphs d through h of Provision 3

c. Paragraph c of Provision 3 also apply, if equipment/property purchases are delegated to subcontractors that are nonprofit organizations or commercial businesses.

d. Nonprofit organizations and commercial businesses, whether acting as a contractor and/or subcontractor, may secure commodities, supplies, equipment/property and services related to such purchases for performance under this Agreement.

(1) Equipment/property purchases not exceed $50,000 annually.

To secure equipment/property above the annual maximum limit of $50,000, the Contractor make arrangements through the appropriate DHCS Program Contract Manager, to have all remaining equipment/property purchased through DHCS' Purchasing Unit. The cost of equipment/property purchased by or through DHCS be deducted from

the funds available in this Agreement. Contractor submit to the DHCS Program Contract Manager a list of equipment/property specifications for those items that the State must procure. DHCS may pay the vendor directly for such arranged equipment/property purchases and title to the equipment/property will remain with DHCS. The equipment/property will be delivered to the Contractor's address, as stated on the face of the Agreement, unless the Contractor notifies the DHCS Program Contract Manager, in writing, of an alternate delivery address.

(2) All equipment/property purchases are subject to Paragraphs d through h of Provision 3. Paragraph b of Provision 3 also apply, if equipment/property purchases are delegated to Subcontractors that are either a government or public entity.

(3) Nonprofit organizations and commercial businesses use a procurement system that meets the following standards:

(a) Maintain a code or standard of conduct that govern the performance of its officers, employees, or agents engaged in awarding procurement contracts. No employee, officer, or agent shall participate in the selection, award, or administration of a procurement, or bid contract in which, to his or her knowledge, he or she has a financial interest.

(b) Procurements be conducted in a manner that provides, to the maximum extent practical, open, and free competition.

(c) Procurements be conducted in a manner that provides for all of the following:

[1] Avoid purchasing unnecessary or duplicate items.

[2] Equipment/property solicitations be based upon a clear and accurate description of the technical requirements of the goods to be procured.

[3] Take positive steps to utilize small and veteran owned businesses.

e. Unless waived or otherwise stipulated in writing by DHCS, prior written authorization from the appropriate DHCS Program Contract Manager will be required before the Contractor will be reimbursed for any purchase of $5,000 or more for commodities, supplies, equipment/property, and services related to such purchases. The Contractor must provide in its request for authorization all particulars necessary, as specified by DHCS, for evaluating the necessity or desirability of incurring such costs. The term "purchase" excludes the purchase of services from a subcontractor and public utility services at rates established for uniform applicability to the general public.

f. In special circumstances, determined by DHCS (e.g., when DHCS has a need to monitor certain purchases, etc.), DHCS may require prior written authorization and/or the submission of paid vendor receipts for any purchase, regardless of dollar amount. DHCS reserves the right to either deny claims for reimbursement or to request repayment for any Contractor and/or subcontractor purchase that DHCS determines to be unnecessary in carrying out performance under this Agreement.

g. The Contractor and/or subcontractor must maintain a copy or narrative description of the procurement system, guidelines, rules, or regulations that will be used to make purchases under this Agreement. The State reserves the right to request a copy of these documents and to inspect the purchasing practices of the Contractor and/or subcontractor at any time.

h. For all purchases, the Contractor and/or subcontractor must maintain copies of all paid vendor invoices, documents, bids and other information used in vendor selection, for inspection or audit. Justifications supporting the absence of bidding (i.e., sole source purchases) also be maintained on file by the Contractor and/or subcontractor for inspection or audit.

i. DHCS may, with cause (e.g., with reasonable suspicion of unnecessary purchases or use of inappropriate purchase practices, etc.), withhold, cancel, modify, or retract the delegated purchase authority granted under Paragraphs b and/or c of Provision 3 by giving the Contractor no less than 30 calendar days written notice.

4. Equipment/Property Ownership / Inventory / Disposition

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

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

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

(1) **Reporting of Equipment/Property Receipt**

DHCS requires the reporting, tagging and annual inventorying of all equipment and/or property that is furnished by DHCS or purchased/reimbursed with funds provided through this Agreement.

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

(2) **Annual Equipment/Property Inventory**

If the Contractor enters into an agreement with a term of more than twelve months, the Contractor submit an annual inventory of State equipment and/or property to the DHCS Program Contract Manager using a form or format designated by DHCS' Asset Management Unit. If an inventory report form (i.e., Inventory/Disposition of DHCS-Funded Equipment) does not accompany

this Agreement, Contractor request a copy from the DHCS Program Contract Manager. Contractor:

(a) Include in the inventory report, equipment and/or property in the Contractor's possession and/or in the possession of a subcontractor (including independent consultants).

(b) Submit the inventory report to DHCS according to the instructions appearing on the inventory form or issued by the DHCS Program Contract Manager.

(c) Contact the DHCS Program Contract Manager to learn how to remove, trade-in, sell, transfer or survey off, from the inventory report, expired equipment and/or property that is no longer wanted, usable or has passed its life expectancy. Instructions will be supplied by either the DHCS Program Contract Manager or DHCS' Asset Management Unit.

b. Title to State equipment and/or property not be affected by its incorporation or attachment to any property not owned by the State.

c. Unless otherwise stipulated, DHCS be under no obligation to pay the cost of restoration, or rehabilitation of the Contractor's and/or Subcontractor's facility which may be affected by the removal of any State equipment and/or property.

d. The Contractor and/or Subcontractor maintain and administer a sound business program for ensuring the proper use, maintenance, repair, protection, insurance and preservation of State equipment and/or property.

(1) In administering this provision, DHCS may require the Contractor and/or Subcontractor to repair or replace, to DHCS' satisfaction, any damaged, lost or stolen State equipment and/or property. In the event of State equipment and/or miscellaneous property theft, Contractor and/or Subcontractor immediately file a theft report with the appropriate police agency or the California Highway Patrol and Contractor promptly submit one copy of the theft report to the DHCS Program Contract Manager.

e. Unless otherwise stipulated by the Program funding this Agreement, equipment and/or property purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, only be used for performance of this Agreement or another DHCS agreement.

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

f. **Motor Vehicles**

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

(1) If motor vehicles are purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, within thirty (30) calendar days prior to the termination or end of this Agreement, the Contractor and/or Subcontractor return such vehicles to DHCS and deliver all necessary documents of title or registration to enable the proper transfer of a marketable title to DHCS.

(2) If motor vehicles are purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, the State of California be the legal owner of said motor vehicles and the Contractor be the registered owner. The Contractor and/or a subcontractor may only use said vehicles for performance and under the terms of this Agreement.

(3) The Contractor and/or Subcontractor agree that all operators of motor vehicles, purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, hold a valid State of California driver's license. In the event that ten or more passengers are to be transported in any one vehicle, the operator also hold a State of California Class B driver's license.

(4) If any motor vehicle is purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, the Contractor and/or Subcontractor, as applicable, provide, maintain, and certify that, at a minimum, the following type and amount of automobile liability insurance is in effect during the term of this Agreement or any extension period during which any vehicle remains in the Contractor's and/or Subcontractor's possession:

Automobile Liability Insurance

(a) The Contractor, by signing this Agreement, hereby certifies that it possesses or will obtain automobile liability insurance in the amount of $1,000,000 per occurrence for bodily injury and property damage combined. Said insurance must be obtained and made effective upon the delivery date of any motor vehicle, purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, to the Contractor and/or Subcontractor.

(b) The Contractor and/or Subcontractor, as soon as practical, furnish a copy of the certificate of insurance to the DHCS Program Contract Manager. The certificate of insurance identify the DHCS contract or agreement number for which the insurance applies.

(c) The Contractor and/or Subcontractor agree that bodily injury and property damage liability insurance, as required herein, remain in effect at all times during the term of this Agreement or until such time as the motor vehicle is returned to DHCS.

(d) The Contractor and/or Subcontractor agree to provide, at least thirty (30) days prior to the expiration date of said insurance coverage, a copy of a new certificate of insurance evidencing continued coverage, as indicated herein, for not less than the remainder of the term of this Agreement, the term of any extension or continuation thereof, or for a period of not less than one (1) year.

(e) The Contractor and/or Subcontractor, if not a self-insured government and/or public entity, must provide evidence, that any required certificates of insurance contain the following provisions:

[1] The insurer will not cancel the insured's coverage without giving thirty (30) calendar days prior written notice to the State (California Department of Health Care Services).

[2] The State of California, its officers, agents, employees, and servants are included as additional insureds, but only with respect to work performed for the State under this Agreement and any extension or continuation of this Agreement.

[3] The insurance carrier notify the California Department of Health Care Services (DHCS), in writing, of the Contractor's failure to pay premiums; its cancellation of such policies; or any other substantial change, including, but not limited to, the status, coverage, or scope of the required insurance. Such notices contain a reference to each agreement number for which the insurance was obtained.

(f) The Contractor and/or Subcontractor is hereby advised that copies of certificates of insurance may be subject to review and approval by the Department of General Services (DGS), Office of Risk and Insurance Management. The Contractor be notified by DHCS, in writing, if this provision is applicable to this Agreement. If DGS approval of the certificate of insurance is required, the Contractor agrees that no work or services shall be performed prior to obtaining said approval.

(g) In the event the Contractor and/or Subcontractor fails to keep insurance coverage, as required herein, in effect at all times during vehicle possession, DHCS may, in addition to any other remedies it may have, terminate this Agreement upon the occurrence of such event.

5. Subcontract Requirements

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

a. Prior written authorization will be required before the Contractor enters into or is reimbursed for any subcontract for services costing $5,000 or more. Except as indicated in Paragraph a(3) herein, when securing subcontracts for services exceeding $5,000, the Contractor obtain at least three bids or justify a sole source award.

(1) The Contractor must provide in its request for authorization, all information necessary for evaluating the necessity or desirability of incurring such cost.

(2) DHCS may identify the information needed to fulfill this requirement.

(3) Subcontracts performed by the following entities or for the service types listed below are exempt from the bidding and sole source justification requirements:

(a) A local governmental entity or the federal government,

(b) A State college or State university from any State,

(c) A Joint Powers Authority,

(d) An auxiliary organization of a California State University or a California community college,

(e) A foundation organized to support the Board of Governors of the California Community Colleges,

(f) An auxiliary organization of the Student Aid Commission established under Education Code § 69522,

(g) Firms or individuals proposed for use and approved by DHCS' funding Program via acceptance of an application or proposal for funding or pre/post contract award negotiations,

(h) Entities and/or service types identified as exempt from advertising and competitive bidding in State Contracting Manual Chapter 5 Section 5.80 Subsection B.2.

b. DHCS reserves the right to approve or disapprove the selection of subcontractors and with advance written notice, require the substitution of subcontractors and require the Contractor to terminate subcontracts entered into in support of this Agreement.

(1) Upon receipt of a written notice from DHCS requiring the substitution and/or termination of a subcontract, the Contractor take steps to ensure the completion of any work in progress and select a replacement, if applicable, within 30 calendar days, unless a longer period is agreed to by DHCS.

c. Actual subcontracts (i.e., written agreement between the Contractor and a subcontractor) of $5,000 or more are subject to the prior review and written approval of DHCS. DHCS may, at its discretion, elect to waive this right. All such waivers be confirmed in writing by DHCS.

d. Contractor maintain a copy of each subcontract entered into in support of this Agreement and, upon request by DHCS, make copies available for approval, inspection, or audit.

e. DHCS assumes no responsibility for the payment of subcontractors used in the performance of this Agreement. Contractor accepts sole responsibility for the payment of subcontractors used in the performance of this Agreement.

f. The Contractor is responsible for all performance requirements under this Agreement even though performance may be carried out through a subcontract.

g. The Contractor ensure that all subcontracts for services include provision(s) requiring compliance with applicable terms and conditions specified in this Agreement.

h. The Contractor agrees to include the following clause, relevant to record retention, in all subcontracts for services:

"(Subcontractor Name) agrees to maintain and preserve, until three years after termination of (Agreement Number) and final payment from DHCS to the Contractor, to permit DHCS or any duly authorized representative, to have access to, examine or audit any pertinent books, documents, papers and records related to this subcontract and to allow interviews of any employees who might reasonably have information related to such records."

i. Unless otherwise stipulated in writing by DHCS, the Contractor be the subcontractor's sole point of contact for all matters related to performance and payment under this Agreement.

j. Contractor, as applicable, advise all subcontractors of their obligations pursuant to the following numbered provisions of this Exhibit: 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, 12, 13, 14, 17, 19, 20, 24, 32 and/or other numbered provisions herein that are deemed applicable.

6. Income Restrictions

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

7. Audit and Record Retention

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

a. The Contractor and/or Subcontractor maintain books, records, documents, and other evidence, accounting procedures and practices, sufficient to properly reflect all direct and indirect costs of whatever nature claimed to have been incurred in the performance of this Agreement, including any matching costs and expenses. The foregoing constitutes "records" for the purpose of this provision.

b. The Contractor's and/or subcontractor's facility or office or such part thereof as may be engaged in the performance of this Agreement and his/her records be subject at all reasonable times to inspection, audit, and reproduction.

c. Contractor agrees that DHCS, the Department of General Services, the Bureau of State Audits, or their designated representatives including the Comptroller General of the United States have the right to review and to copy any records and supporting documentation pertaining to the performance of this Agreement.

Contractor agrees to allow the auditor(s) access to such records during normal business hours and to allow interviews of any employees who might reasonably have information related to such records. Further, the Contractor agrees to include a similar right of the State to audit records and interview staff in any subcontract related to performance of this Agreement. (Government Code Section 8546.7, Public Contract Code (PCC) Sections 10115 et seq., Code of California Regulations Title 2, Section 1896.77.) The Contractor comply with the above and be aware of the penalties for violations of fraud and for obstruction of investigation as set forth in PCC Section10115.10.

d. The Contractor and/or Subcontractor preserve and make available his/her records (1) for a period of six years for all records related to Disabled Veteran Business Enterprise (DVBE) participation (Military and Veterans Code 999.55), if this Agreement involves DVBE participation, and three years for all other contract records from the date of final payment under this Agreement, and (2) for such longer period, if any, as is required by applicable statute, by any other provision of this Agreement, or by subparagraphs (1) or (2) below.

   (1) If this Agreement is completely or partially terminated, the records relating to the work terminated be preserved and made available for a period of three years from the date of any resulting final settlement.

   (2) If any litigation, claim, negotiation, audit, or other action involving the records has been started before the expiration of the three-year period, the records be retained until completion of the action and resolution of all issues which arise from it, or until the end of the regular three-year period, whichever is later.

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

f. The Contractor, if applicable, comply with the Single Audit Act and the audit requirements set forth in 2 C.F.R. § 200.501 (2014).

8. Site Inspection

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

9. Federal Contract Funds

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

a. It is mutually understood between the parties that this Agreement may have been written before ascertaining the availability of congressional appropriation of funds, for the mutual benefit of both parties, in order to avoid program and fiscal delays which would occur if the Agreement were executed after that determination was made.

b. This agreement is valid and enforceable only if sufficient funds are made available to the State by the United States Government for the fiscal years covered by the term of this Agreement. In addition, this Agreement is subject to any additional restrictions, limitations, or conditions enacted by the Congress or any statute enacted by the Congress which may affect the provisions, terms or funding of this Agreement in any manner.

c. It is mutually agreed that if the Congress does not appropriate sufficient funds for the program, this Agreement be amended to reflect any reduction in funds.

d. DHCS has the option to invalidate or cancel the Agreement with 30-days advance written notice or to amend the Agreement to reflect any reduction in funds.

10. Termination

a. **For Cause**

The State may terminate this Agreement, in whole or in part, and be relieved of any payments should the Contractor fail to perform the requirements of this Agreement at the time and in the manner herein provided. In the event of such termination, the State may proceed with the work in any manner deemed proper by the State. All costs to the State be deducted from any sum due the Contractor under this Agreement and the balance, if any, be paid to the Contractor upon demand. If this Agreement is terminated, in whole or in part, the State may require the Contractor to transfer title, or in the case of licensed software, license, and deliver to the State any completed deliverables, partially completed deliverables, and any other materials, related to the terminated portion of the Contract, including but not limited to, computer programs, data files, user and operations manuals, system and program documentation, training programs related to the operation and maintenance of the system, and all information necessary for the reimbursement of any outstanding Medicaid claims. The State pay contract price for completed deliverables delivered and accepted and items the State requires the Contractor to transfer as described in this paragraph above.

b. **For Convenience**

The State retains the option to terminate this Agreement, in whole or in part, without cause, at the State's convenience, without penalty, provided that written notice has been delivered to the Contractor at least ninety (90) calendar days

prior to such termination date. In the event of termination, in whole or in part, under this paragraph, the State may require the Contractor to transfer title, or in the case of licensed software, license, and deliver to the State any completed deliverables, partially completed deliverables, and any other materials related to the terminated portion of the contract including but not limited to, computer programs, data files, user and operations manuals, system and program documentation, training programs related to the operation and maintenance of the system, and all information necessary for the reimbursement of any outstanding Medicaid claims. The Contractor will be entitled to compensation upon submission of an invoice and proper proof of claim for the services and products satisfactorily rendered, subject to all payment provisions of the Agreement. Payment is limited to expenses necessarily incurred pursuant to this Agreement up to the date of termination.

11. Intellectual Property Rights

a. **Ownership**

(1) Except where DHCS has agreed in a signed writing to accept a license, DHCS be and remain, without additional compensation, the sole owner of any and all rights, title and interest in all Intellectual Property, from the moment of creation, whether or not jointly conceived, that are made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement.

(2) For the purposes of this Agreement, Intellectual Property means recognized protectable rights and interest such as: patents, (whether or not issued) copyrights, trademarks, service marks, applications for any of the foregoing, inventions, trade secrets, trade dress, logos, insignia, color combinations, slogans, moral rights, right of publicity, author's rights, contract and licensing rights, works, mask works, industrial design rights, rights of priority, know how, design flows, methodologies, devices, business processes, developments, innovations, good will and all other legal rights protecting intangible proprietary information as may exist now and/or here after come into existence, and all renewals and extensions, regardless of whether those rights arise under the laws of the United States, or any other state, country or jurisdiction.

(a) For the purposes of the definition of Intellectual Property, "works" means all literary works, writings and printed matter including the medium by which they are recorded or reproduced, photographs, art work, pictorial and graphic representations and works of a similar nature, film, motion pictures, digital images, animation cells, and other audiovisual works including positives and negatives thereof, sound recordings, tapes, educational materials, interactive videos and any other materials or products created, produced, conceptualized and fixed in a tangible medium of expression. It includes preliminary and final products and any materials and information developed for the purposes of producing those final products. Works does not include articles submitted to peer review or reference journals or independent research projects.

(3) In the performance of this Agreement, Contractor will exercise and utilize certain of its Intellectual Property in existence prior to the effective date of this Agreement. In addition, under this Agreement, Contractor may access and utilize certain of DHCS' Intellectual Property in existence prior to the effective date of this Agreement. Except as otherwise set forth herein, Contractor not use any of DHCS' Intellectual Property now existing or hereafter existing for any purposes without the prior written permission of DHCS. Except as otherwise set forth herein, neither the Contractor nor DHCS give any ownership interest in or rights to its Intellectual Property to the other Party. If during the term of this Agreement, Contractor accesses any third-party Intellectual Property that is licensed to DHCS, Contractor agrees to abide by all license and confidentiality restrictions applicable to DHCS in the third-party's license agreement.

(4) Contractor agrees to cooperate with DHCS in establishing or maintaining DHCS' exclusive rights in the Intellectual Property, and in assuring DHCS' sole rights against third parties with respect to the Intellectual Property. If the Contractor enters into any agreements or subcontracts with other parties in order to perform this Agreement, Contractor require the terms of the Agreement(s) to include all Intellectual Property provisions. Such terms must include, but are not limited to, the subcontractor assigning and agreeing to assign to DHCS all rights, title and interest in Intellectual Property made, conceived, derived from, or reduced to practice by the subcontractor, Contractor or DHCS and which result directly or indirectly from this Agreement or any subcontract.

(5) Contractor further agrees to assist and cooperate with DHCS in all reasonable respects, and execute all documents and, subject to reasonable availability, give testimony and take all further acts reasonably necessary to acquire, transfer, maintain, and enforce DHCS' Intellectual Property rights and interests.

b. **Retained Rights / License Rights**

(1) Except for Intellectual Property made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement, Contractor retain title to all of its Intellectual Property to the extent such Intellectual Property is in existence prior to the effective date of this Agreement. Contractor hereby grants to DHCS, without additional compensation, a permanent, non-exclusive, royalty free, paid-up, worldwide, irrevocable, perpetual, non-terminable license to use, reproduce, manufacture, sell, offer to sell, import, export, modify, publicly and privately display/perform, distribute, and dispose Contractor's Intellectual Property with the right to sublicense through multiple layers, for any purpose whatsoever, to the extent it is incorporated in the Intellectual Property resulting from this Agreement, unless Contractor assigns all rights, title and interest in the Intellectual Property as set forth herein.

(2) Nothing in this provision shall restrict, limit, or otherwise prevent Contractor from using any ideas, concepts, know-how, methodology or techniques related to its performance under this Agreement, provided that Contractor's use does not infringe the patent, copyright, trademark rights, license or other

Intellectual Property rights of DHCS or third party, or result in a breach or default of any provisions of this Exhibit or result in a breach of any provisions of law relating to confidentiality.

c. **Copyright**

(1) Contractor agrees that for purposes of copyright law, all works [as defined in Paragraph a, subparagraph (2)(a) of this provision] of authorship made by or on behalf of Contractor in connection with Contractor's performance of this Agreement be deemed "works made for hire". Contractor further agrees that the work of each person utilized by Contractor in connection with the performance of this Agreement will be a "work made for hire," whether that person is an employee of Contractor or that person has entered into an agreement with Contractor to perform the work. Contractor enter into a written agreement with any such person that: (i) all work performed for Contractor be deemed a "work made for hire" under the Copyright Act and (ii) that person assign all right, title, and interest to DHCS to any work product made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement.

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

d. **Patent Rights**

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

e. **Third-Party Intellectual Property**

Except as provided herein, Contractor agrees that its performance of this Agreement not be dependent upon or include any Intellectual Property of Contractor or third party without first: (i) obtaining DHCS' prior written approval; and (ii) granting to or obtaining for DHCS, without additional compensation, a license, as described in Section b of this provision, for any of Contractor's or

third-party's Intellectual Property in existence prior to the effective date of this Agreement. If such a license upon these terms is unattainable, and DHCS determines that the Intellectual Property should be included in or is required for Contractor's performance of this Agreement, Contractor obtain a license under terms acceptable to DHCS.

f. **Warranties**

(1) Contractor represents and warrants that:

(a) It is free to enter into and fully perform this Agreement.

(b) It has secured and will secure all rights and licenses necessary for its performance of this Agreement.

(c) Neither Contractor's performance of this Agreement, nor the exercise by either Party of the rights granted in this Agreement, nor any use, reproduction, manufacture, sale, offer to sell, import, export, modification, public and private display/performance, distribution, and disposition of the Intellectual Property made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement will infringe upon or violate any Intellectual Property right, non-disclosure obligation, or other proprietary right or interest of any third-party or entity now existing under the laws of, or hereafter existing or issued by, any state, the United States, or any foreign country. There is currently no actual or threatened claim by any such third-party based on an alleged violation of any such right by Contractor.

(d) Neither Contractor's performance nor any part of its performance will violate the right of privacy of, or constitute a libel or slander against any person or entity.

(e) It has secured and will secure all rights and licenses necessary for Intellectual Property including, but not limited to, consents, waivers or releases from all authors of music or performances used, and talent (radio, television and motion picture talent), owners of any interest in and to real estate, sites, locations, property or props that may be used or shown.

(f) It has not granted and not grant to any person or entity any right that would or might derogate, encumber, or interfere with any of the rights granted to DHCS in this Agreement.

(g) It has appropriate systems and controls in place to ensure that State funds will not be used in the performance of this Agreement for the acquisition, operation or maintenance of computer software in violation of copyright laws.

(h) It has no knowledge of any outstanding claims, licenses or other charges, liens, or encumbrances of any kind or nature whatsoever that could affect in any way Contractor's performance of this Agreement.

(2) DHCS makes no warranty that the intellectual property resulting from this agreement does not infringe upon any patent, trademark, copyright or the like, now existing or subsequently issued.

g. **Intellectual Property Indemnity**

(1) Contractor indemnify, defend and hold harmless DHCS and its licensees and assignees, and its officers, directors, employees, agents, representatives, successors, and users of its products, ("Indemnitees") from and against all claims, actions, damages, losses, liabilities (or actions or proceedings with respect to any thereof), whether or not rightful, arising from any and all actions or claims by any third party or expenses related thereto (including, but not limited to, all legal expenses, court costs, and attorney's fees incurred in investigating, preparing, serving as a witness in, or defending against, any such claim, action, or proceeding, commenced or threatened) to which any of the Indemnitees may be subject, whether or not Contractor is a party to any pending or threatened litigation, which arise out of or are related to (i) the incorrectness or breach of any of the representations, warranties, covenants or agreements of Contractor pertaining to Intellectual Property; or (ii) any Intellectual Property infringement, or any other type of actual or alleged infringement claim, arising out of DHCS' use, reproduction, manufacture, sale, offer to sell, distribution, import, export, modification, public and private performance/display, license, and disposition of the Intellectual Property made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement. This indemnity obligation apply irrespective of whether the infringement claim is based on a patent, trademark or copyright registration that issued after the effective date of this Agreement. DHCS reserves the right to participate in and/or control, at Contractor's expense, any such infringement action brought against DHCS.

(2) Should any Intellectual Property licensed by the Contractor to DHCS under this Agreement become the subject of an Intellectual Property infringement claim, Contractor will exercise its authority reasonably and in good faith to preserve DHCS' right to use the licensed Intellectual Property in accordance with this Agreement at no expense to DHCS. DHCS have the right to monitor and appear through its own counsel (at Contractor's expense) in any such claim or action. In the defense or settlement of the claim, Contractor may obtain the right for DHCS to continue using the licensed Intellectual Property; or, replace or modify the licensed Intellectual Property so that the replaced or modified Intellectual Property becomes non-infringing provided that such replacement or modification is functionally equivalent to the original licensed Intellectual Property. If such remedies are not reasonably available, DHCS be entitled to a refund of all monies paid under this Agreement, without restriction or limitation of any other rights and remedies available at law or in equity.

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

jurisdiction, without restriction or limitation of any other rights and remedies available at law or in equity.

h. **Federal Funding**

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

i. **Survival**

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

12. Air or Water Pollution Requirements

Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt by law.

a. Government contractors agree to comply with all applicable standards, orders, or requirements issued under section 306 of the Clean Air Act (42 USC 7606) section 508 of the Clean Water Act (33 U.S.C. 1368), Executive Order 11738, and Environmental Protection Agency regulations.

b. Institutions of higher education, hospitals, nonprofit organizations and commercial businesses agree to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 U.S.C. 7401 et seq.), as amended, and the Clean Water Act (33 U.S.C. 1251 et seq.), as amended.

13. Prior Approval of Training Seminars, Workshops or Conferences

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

14. Confidentiality of Information

a. The Contractor and its employees, agents, or subcontractors protect from unauthorized disclosure names and other identifying information concerning persons either receiving services pursuant to this Agreement or persons whose names or identifying information become available or are disclosed to the Contractor, its employees, agents, or subcontractors as a result of services

performed under this Agreement, except for statistical information not identifying any such person.

b. The Contractor and its employees, agents, or subcontractors not use such identifying information for any purpose other than carrying out the Contractor's obligations under this Agreement.

c. The Contractor and its employees, agents, or subcontractors promptly transmit to the DHCS Program Contract Manager all requests for disclosure of such identifying information not emanating from the client or person.

d. The Contractor not disclose, except as otherwise specifically permitted by this Agreement or authorized by the client, any such identifying information to anyone other than DHCS without prior written authorization from the DHCS Program Contract Manager, except if disclosure is required by State or federal law.

e. For purposes of this provision, identity include, but not be limited to name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

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

15. Documents, Publications and Written Reports

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

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

16. Dispute Resolution Process

a. A Contractor grievance exists whenever there is a dispute arising from DHCS' action in the administration of an agreement. If there is a dispute or grievance between the Contractor and DHCS, the Contractor must seek resolution using the procedure outlined below.

(1) The Contractor should first informally discuss the problem with the DHCS Program Contract Manager. If the problem cannot be resolved informally, the Contractor direct its grievance together with any evidence, in writing, to the program Branch Chief. The grievance state the issues in dispute, the legal authority or other basis for the Contractor's position and the remedy sought. The Branch Chief render a decision within ten (10) Working Days after receipt of the written grievance from the Contractor. The Branch Chief respond in writing to the Contractor indicating the decision and reasons therefore. If the

Contractor disagrees with the Branch Chief's decision, the Contractor may appeal to the second level.

(2) When appealing to the second level, the Contractor must prepare an appeal indicating the reasons for disagreement with Branch Chief's decision. The Contractor must include with the appeal a copy of the Contractor's original statement of dispute along with any supporting evidence and a copy of the Branch Chief's decision. The appeal be addressed to the Deputy Director of the division in which the branch is organized within ten (10) Working Days from receipt of the Branch Chief's decision. The Deputy Director of the division in which the branch is organized or his/her designee meet with the Contractor to review the issues raised. A written decision signed by the Deputy Director of the division in which the branch is organized or his/her designee be directed to the Contractor within twenty (20) working days of receipt of the Contractor's second level appeal.

b. If the Contractor wishes to appeal the decision of the Deputy Director of the division in which the branch is organized or his/her designee, the Contractor follow the procedures set forth in Health and Safety Code Section 100171.

c. Unless otherwise stipulated in writing by DHCS, all dispute, grievance and/or appeal correspondence be directed to the DHCS Program Contract Manager.

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

17. Financial and Compliance Audit Requirements

a. The definitions used in this provision are contained in Section 38040 of the Health and Safety Code, which by this reference is made a part hereof.

b. Direct service contract means a contract or agreement for services contained in local assistance or subvention programs or both (see Health and Safety [H&S] Code Section 38020). Direct service contracts do not include contracts, agreements, grants, or subventions to other governmental agencies or units of government nor contracts or agreements with regional centers or area agencies on aging (H&S Code Section 38030).

c. The Contractor, as indicated below, agrees to obtain one of the following audits:

(1) ***If the Contractor is a nonprofit organization (as defined in H&S Code Section 38040)*** and receives **$25,000 or more** from any State agency under a direct service contract or agreement; the Contractor agrees to obtain an annual single, organization wide, financial and compliance audit. Said audit be conducted according to Generally Accepted Auditing Standards. This audit does not fulfill the audit requirements of Paragraph c(3) below. The audit be completed by the 15th day of the fifth month following the end of the Contractor's fiscal year, and/or

(2) ***If the Contractor is a nonprofit organization (as defined in H&S Code Section 38040)*** and receives **less than $25,000** per year from any State agency under a direct service contract or agreement, the Contractor agrees to obtain a biennial single, organization wide financial and compliance audit, unless there is evidence of fraud or other violation of State law in connection with this Agreement. This audit does not fulfill the audit requirements of Paragraph c(3) below. The audit be completed by the 15th day of the fifth month following the end of the Contractor's fiscal year, and/or

(3) ***If the Contractor is a State or Local Government entity or Nonprofit organization*** and expends $750,000 or more in federal awards, the Contractor agrees to obtain an annual single, organization wide, financial and compliance audit according to the requirements specified in 2 C.F.R. 200.501 entitled "Audit Requirements". An audit conducted pursuant to this provision will fulfill the audit requirements outlined in Paragraphs c(1) and c(2) above. The audit be completed by the end of the ninth month following the end of the audit period. The requirements of this provision apply if:

(a) The Contractor is a recipient expending federal awards received directly from federal awarding agencies, or

(b) The Contractor is a subrecipient expending federal awards received from a pass-through entity such as the State, County or community based organization.

(4) If the Contractor submits to DHCS a report of an audit other than a 2 C.F.R. 200.501audit, the Contractor must also submit a certification indicating the Contractor has not expended $750,000 or more in federal funds for the year covered by the audit report.

d. Two copies of the audit report be delivered to the DHCS program funding this Agreement. The audit report must identify the Contractor's legal name and the number assigned to this Agreement. The audit report be due within 30 days after the completion of the audit. Upon receipt of said audit report, the DHCS Program Contract Manager forward the audit report to DHCS' Audits and Investigations Unit if the audit report was submitted under Section 16.c(3), unless the audit report is from a City, County, or Special District within the State of California whereby the report will be retained by the funding program.

e. The cost of the audits described herein may be included in the funding for this Agreement up to the proportionate amount this Agreement represents of the Contractor's total revenue. The DHCS program funding this Agreement must provide advance written approval of the specific amount allowed for said audit expenses.

f. The State or its authorized designee, including the Bureau of State Audits, is responsible for conducting agreement performance audits which are not financial and compliance audits. Performance audits are defined by Generally Accepted Government Auditing Standards.

g. Nothing in this Agreement limits the State's responsibility or authority to enforce State law or regulations, procedures, or reporting requirements arising thereto.

h. Nothing in this provision limits the authority of the State to make audits of this Agreement, provided however, that if independent audits arranged for by the Contractor meet Generally Accepted Governmental Auditing Standards, the State rely on those audits and any additional audit work and build upon the work already done.

i. The State may, at its option, direct its own auditors to perform either of the audits described above. The Contractor will be given advance written notification, if the State chooses to exercise its option to perform said audits.

j. The Contractor must include a clause in any agreement the Contractor enters into with the audit firm doing the single organization wide audit to provide access by the State or Federal Government to the working papers of the independent auditor who prepares the single organization wide audit for the Contractor.

k. Federal or State auditors have "expanded scope auditing" authority to conduct specific program audits during the same period in which a single organization wide audit is being performed, but the audit report has not been issued. The federal or State auditors review and have access to the current audit work being conducted and will not apply any testing or review procedures which have not been satisfied by previous audit work that has been completed.

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

18. Human Subjects Use Requirements

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

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

19. Novation Requirements

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

20. Debarment and Suspension Certification

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

a. By signing this Agreement, the Contractor/Grantee agrees to comply with applicable federal suspension and debarment regulations including, but not limited to 2 CFR Part 180, 2 CFR Part 376

b. By signing this Agreement, the Contractor certifies to the best of its knowledge and belief, that it and its principals:

   (1) Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency;

   (2) Have not within a three-year period preceding this application/proposal/agreement been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, State or local) violation of federal or State antitrust statutes; or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, receiving stolen property, making false claims, obstruction of justice, or the commission of any other offense indicating a lack of business integrity or business honesty that seriously affects its business honesty;

   (3) Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (federal, State or local) with commission of any of the offenses enumerated in Paragraph b(2) herein; and

   (4) Have not within a three-year period preceding this application/proposal/agreement had one or more public transactions (federal, State or local) terminated for cause or default.

   (5) Have not, within a three-year period preceding this application/proposal/agreement, engaged in any of the violations listed under 2 CFR Part 180, Subpart C as supplemented by 2 CFR Part 376.

   (6) not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under federal regulations (i.e., 48 CFR part 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State.

   (7) Will include a clause entitled, "Debarment and Suspension Certification" that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

c. If the Contractor is unable to certify to any of the statements in this certification, the Contractor submit an explanation to the DHCS Program Contract Manager.

d. The terms and definitions herein have the meanings set out in 2 CFR Part 180 as supplemented by 2 CFR Part 376.

e. If the Contractor knowingly violates this certification, in addition to other remedies available to the Federal Government, DHCS may terminate this Agreement for cause or default.

21. Smoke-Free Workplace Certification

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

a. Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through State or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed.

b. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible party.

c. By signing this Agreement, Contractor or Grantee certifies that it will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The prohibitions herein are effective December 26, 1994.

d. Contractor or Grantee further agrees that it will insert this certification into any subawards (subcontracts or subgrants) entered into that provide for children's services as described in the Act.

22. Drug Free Workplace Act of 1988

The Federal government implemented the Drug Free Workplace Act of 1988 in an attempt to address the problems of drug abuse on the job. It is a fact that employees who use drugs have less productivity, a lower quality of work, and a higher absenteeism, and are more likely to misappropriate funds or services. From this perspective, the drug abuser may endanger other employees, the public at large, or themselves. Damage to property, whether owned by this entity or not, could result from drug abuse on the job. All these actions might undermine public confidence in the services this entity provides. Therefore, in order to remain a responsible source for government contracts, the following guidelines have been adopted:

a. The unlawful manufacture, distribution, dispensation, possession or use of a controlled substance is prohibited in the work place.

b. Violators may be terminated or requested to seek counseling from an approved rehabilitation service.

c. Employees must notify their employer of any conviction of a criminal drug statue no later than five days after such conviction.

d. Although alcohol is not a controlled substance, it is nonetheless a drug. It is the policy that abuse of this drug will also not be tolerated in the workplace.

e. Contractors of federal agencies are required to certify that they will provide drug-free workplaces for their employees.

23. Covenant Against Contingent Fees

(Applicable only to federally funded agreements.)

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

24. Payment Withholds

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

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

25. Performance Evaluation

(Not applicable to grant agreements.)

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

26. Officials Not to Benefit

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

27. Four-Digit Date Compliance

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

Contractor warrants that it will provide only Four-Digit Date Compliant (as defined below) Deliverables and/or services to the State. “Four Digit Date compliant”

Deliverables and services can accurately process, calculate, compare, and sequence date data, including without limitation date data arising out of or relating to leap years and changes in centuries. This warranty and representation is subject to the warranty terms and conditions of this Contract and does not limit the generality of warranty obligations set forth elsewhere herein.

28. Prohibited Use of State Funds for Software

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

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

29. Use of Disabled Veteran's Business Enterprises (DVBE)

(Applicable to agreements over $10,000 in which the Contractor committed to achieve DVBE participation. Not applicable to agreements and amendments specifically exempted from DVBE requirements by DHCS.)

a. The State Legislature has declared that a fair portion of the total purchases and contracts or subcontracts for property and services for the State be placed with disabled veteran business enterprises.

b. All DVBE participation attachments, however labeled, completed as a condition of bidding, contracting, or amending a subject agreement, are incorporated herein and made a part of this Agreement by this reference.

c. Contractor agrees to use the proposed DVBEs, as identified in previously submitted DVBE participation attachments. Contractor understands and agrees to comply with the requirements set forth in Military and Veterans Code Section 999 et seq. in that should award of this contract be based on part on its commitment to use the DVBE subcontractor(s) identified in its bid or offer, per Military and Veterans Code section 999.5(g), a DVBE subcontractor may only be replaced by another DVBE subcontractor and must be approved by both DHCS and the Department of General Services (DGS) prior to the commencement of any work by the proposed subcontractor. Changes to the scope of work that impact the DVBE subcontractor(s) identified in the bid or offer and approved DVBE substitutions will be documented by contract amendment.

d. Requests for DVBE subcontractor substitution must include:

   (1) A written explanation of the reason for the DVBE substitution.

   (2) A written description of the business enterprise that will be substituted, including its DVBE certification status.

   (3) A written description of the work to be performed by the substituted DVBE subcontractor and an identification of the percentage share/dollar amount of the overall contract that the substituted subcontractor will perform.

e. Failure of the Contractor to seek substitution and adhere to the DVBE

participation level identified in the bid or offer may be cause for contract termination, recovery of damages under rights and remedies due to the State, and penalties as outlined in Military and Veterans Code § 999.9; Public Contract Code (PCC) §10115.10, or PCC §4110 (applies to public works only).

f. Upon completion of this Contract, DHCS requires the Contractor to certify using the Prime Contractor's Certification – DVBE Subcontracting Report (STD 817), all of the following:

   (1) The total amount the prime contractor received under the agreement;

   (2) The name, address, Contract number and certification ID Number of the DVBE(s) that participated in the performance of this Contract;

   (3) The amount and percentage of work the prime Contractor committed to provide to one or more DVBE(s) under the requirements of the Contract and the total payment each DVBE received from the prime Contractor;

   (4) That all payments under the Contract have been made to the DVBE(s); and

   (5) The actual percentage of DVBE participation that was achieved. Upon request, the prime Contractor must provide proof of payment for the work.

g. If for this Contract the Contractor made a commitment to achieve the DVBE participation goal, DHCS will withhold $10,000 from the final payment, or the full payment if less than $10,000, until the Contractor complies with the certification requirements above. A Contractor that fails to comply with the certification requirement must, after written notice, be allowed to cure the defect. Notwithstanding any other law, if, after at least 15 calendar days but not more than 30 calendar days from the date of written notice, the prime Contractor refuses to comply with the certification requirements, DHCS will permanently deduct $10,000 from the final payment, or the full payment if less than $10,000. (Mil. & Vet. Code § 999.7.)

h. A person or entity that knowingly provides false information will be subject to a civil penalty for each violation. (Mil. & Vet. Code § 999.5(d); Govt. Code § 14841.)

i. Contractor agrees to comply with the rules, regulations, ordinances, and statutes that apply to the DVBE program as defined in Section 999 of the Military & Veterans Code, including, but not limited to, the requirements of Section 999.5(d). (PCC§ 10230.)

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

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

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

a. Ensure that small businesses, minority-owned firms, and women's business enterprises are used to the fullest extent practicable.

b. Make information on forthcoming purchasing and contracting opportunities available and arrange time frames for purchases and contracts to encourage and facilitate participation by small businesses, minority-owned firms, and women's business enterprises.

c. Consider in the contract process whether firms competing for larger contracts intend to subcontract with small businesses, minority-owned firms, and women's business enterprises.

d. Encourage contracting with consortiums of small businesses, minority-owned firms and women's business enterprises when a contract is too large for one of these firms to handle individually.

e. Use the services and assistance, as appropriate, of such organizations as the Federal Small Business Administration and the U.S. Department of Commerce's Minority Business Development Agency in the solicitation and utilization of small businesses, minority-owned firms and women's business enterprises.

31. Alien Ineligibility Certification

(Applicable to sole proprietors entering federally funded agreements.)

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

32. Union Organizing

(Applicable only to grant agreements.)

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

a. No State funds disbursed by this grant will be used to assist, promote or deter union organizing.

b. Grantee account for State funds disbursed for a specific expenditure by this grant, to show those funds were allocated to that expenditure.

c. Grantee, where State funds are not designated as described in b herein, allocate, on a pro-rata basis, all disbursements that support the grant program.

d. If Grantee makes expenditures to assist, promote or deter union organizing, Grantee will maintain records sufficient to show that no State funds were used for those expenditures, and that Grantee provide those records to the Attorney General upon request.

33. Contract Uniformity (Fringe Benefit Allowability)

(Applicable only to nonprofit organizations.)

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

a. As used herein fringe benefits shall mean an employment benefit given by one's employer to an employee in addition to one's regular or normal wages or salary.

b. As used herein, fringe benefits do not include:

(1) Compensation for personal services paid currently or accrued by the Contractor for services of employees rendered during the term of this Agreement, which is identified as regular or normal salaries and wages, annual leave, vacation, sick leave, holidays, jury duty and/or military leave/training.

(2) Director's and executive committee member's fees.

(3) Incentive awards and/or bonus incentive pay.

(4) Allowances for off-site pay.

(5) Location allowances.

(6) Hardship pay.

(7) Cost-of-living differentials

c. Specific allowable fringe benefits include:

(1) Fringe benefits in the form of employer contributions for the employer's portion of payroll taxes (i.e., FICA, SUI, SDI), employee health plans (i.e., health, dental and vision), unemployment insurance, worker's compensation insurance, and the employer's share of pension/retirement plans, provided they are granted in accordance with established written organization policies and meet all legal and Internal Revenue Service requirements.

d. To be an allowable fringe benefit, the cost must meet the following criteria:

(1) Be necessary and reasonable for the performance of the Agreement.

(2) Be determined in accordance with generally accepted accounting principles.

(3) Be consistent with policies that apply uniformly to all activities of the Contractor.

e. Contractor agrees that all fringe benefits be at actual cost.

f. Earned/Accrued Compensation

(1) Compensation for vacation, sick leave and holidays is limited to that amount earned/accrued within the agreement term. Unused vacation, sick leave and holidays earned from periods prior to the agreement term cannot be claimed as allowable costs. See Provision f (3)(a) for an example.

(2) For multiple year agreements, vacation and sick leave compensation, which is earned/accrued but not paid, due to employee(s) not taking time off may be carried over and claimed within the overall term of the multiple years of the Agreement. Holidays cannot be carried over from one agreement year to the next. See Provision f (3)(b) for an example.

(3) For single year agreements, vacation, sick leave and holiday compensation that is earned/accrued but not paid, due to employee(s) not taking time off within the term of the Agreement, cannot be claimed as an allowable cost. See Provision f (3)(c) for an example.

(a) **Example No. 1:**

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

(b) **Example No. 2:**

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

(c) **Example No. 3:**

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

34. Suspension or Stop Work Notification

a. DHCS may, at any time, issue a notice to suspend performance or stop work under this Agreement. The initial notification may be a verbal or written directive issued by the funding Program's Contract Manager. Upon receipt of said notice, the Contractor is to suspend and/or stop all, or any part, of the work called for by this Agreement.

b. Written confirmation of the suspension or stop work notification with directions as to what work (if not all) is to be suspended and how to proceed will be provided

within 30 Working Days of the verbal notification. The suspension or stop work notification remain in effect until further written notice is received from DHCS. The resumption of work (in whole or part) will be at DHCS' discretion and upon receipt of written confirmation.

(1) Upon receipt of a suspension or stop work notification, the Contractor immediately comply with its terms and take all reasonable steps to minimize or halt the incurrence of costs allocable to the performance covered by the notification during the period of work suspension or stoppage.

(2) Within 90 days of the issuance of a suspension or stop work notification, DHCS either:

(a) Cancel, extend, or modify the suspension or stop work notification; or

(b) Terminate the Agreement as provided for in the Cancellation / Termination clause of the Agreement.

c. If a suspension or stop work notification issued under this clause is canceled or the period of suspension or any extension thereof is modified or expires, the Contractor may resume work only upon written concurrence of funding Program's Contract Manager.

d. If the suspension or stop work notification is cancelled and the Agreement resumes, changes to the services, deliverables, performance dates, and/or contract terms resulting from the suspension or stop work notification shall require an amendment to the Agreement.

e. If a suspension or stop work notification is not canceled and the Agreement is cancelled or terminated pursuant to the provision entitled Cancellation / Termination, DHCS allow reasonable costs resulting from the suspension or stop work notification in arriving at the settlement costs.

f. DHCS shall not be liable to the Contractor for loss of profits because of any suspension or stop work notification issued under this clause.

35. Public Communications

"Electronic and printed documents developed and produced, for public communications follow the following requirements to comply with Section 508 of the Rehabilitation Act and the American with Disabilities Act:

a. Ensure visual-impaired, hearing-impaired and other special needs audiences are provided material information in formats that provide the most assistance in making informed choices."

36. Compliance with Statutes and Regulations

a. The Contractor must comply with all California and federal law, regulations, and published guidelines, to the extent that these authorities contain requirements applicable to Contractor's performance under the Agreement.

b. These authorities include, but are not limited to, Title 2, Code of Federal Regulations (CFR) Part 200, subpart F, Appendix II; Title 42 CFR Part 431, subpart F; Title 42 CFR Part 433, subpart D; Title 42 CFR Part 434; Title 45 CFR Part 75, subpart D; and Title 45 CFR Part 95, subpart F. To the extent applicable under federal law, this Agreement incorporate the contractual provisions in these federal regulations and they supersede any conflicting provisions in this Agreement.

37. Lobbying Restrictions and Disclosure Certification

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

a. Certification and Disclosure Requirements

(1) Each person (or recipient) who requests or receives a contract or agreement, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds $100,000 at any tier, file a certification (in the form set forth in Attachment 1, consisting of one page, entitled “Certification Regarding Lobbying”) that the recipient has not made, and will not make, any payment prohibited by Paragraph b of this provision.

(2) Each recipient file a disclosure (in the form set forth in Attachment 2, entitled “Standard Form-LLL ‘disclosure of Lobbying Activities’”) if such recipient has made or has agreed to make any payment using nonappropriated funds (to include profits from any covered federal action) in connection with a contract, or grant or any extension or amendment of that contract, or grant, which would be prohibited under Paragraph b of this provision if paid for with appropriated funds.

(3) Each recipient file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by such person under Paragraph a(2) herein. An event that materially affects the accuracy of the information reported includes:

(a) A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action;

(b) A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or

(c) A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action.

(4) Each person (or recipient) who requests or receives from a person referred to in Paragraph a(1) of this provision a contract or agreement, subcontract, grant or subgrant exceeding $100,000 at any tier under a contract or agreement, or grant file a certification, and a disclosure form, if required, to the next tier above.

(5) All disclosure forms (but not certifications) be forwarded from tier to tier until received by the person referred to in Paragraph a(1) of this provision. That person forward all disclosure forms to DHCS Program Contract Manager.

b. Prohibition

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

Attachment 1
CERTIFICATION REGARDING LOBBYING

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

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

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

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

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

Name of Contractor	Printed Name of Person Signing for Contractor
Contract / Grant Number	Signature of Person Signing for Contractor
Date	Title

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

California Department of Health Care Services

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

Attachment 2

CERTIFICATION REGARDING LOBBYING

Approved by OMB (0348-0046)

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352

(See reverse for public burden disclosure)

1. Type of Federal Action:	2. Status of Fedal Action:	3. Report Type:
_ a. contract b. grant c. cooperative agreement d. loan e. loan guarantee f. loan insurance	_ a. bid/offer/application b. initial award c. post-award	_ a. initial filing b. material change For Material Change Only: Year _____ quarter _____ date of last report _____.

4. Name and Address of Reporting Entity:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:
☐Prime ☐Subawardee Tier ___, if known: Congressional District, If known:	Congressional District, If known:
6. Federal Department/Agency	7. Federal Program Name/Description:
	CDFA Number, if applicable: _____
8. Federal Action Number, if known:	9. Award Amount, if known:
10.a. Name and Address of Lobbying Registrant *(If individual, last name, first name, MI)*:	b. Individuals Performing Services *(including address if different from 10a. (Last name, First name, MI):*

11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be available for public inspection. Any person that fails to file the required disclosure shall be subject to a not more than $100,000 for each such failure.	
Signature:	
Print Name:	
Title:	
Telephone Number:	
Date:	
Federal Use Only	Authorized for Local Reproduction Standard Form-LLL (Rev. 7-97)

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

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

1. Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

2. Identify the status of the covered federal action.

3. Identify the appropriate classification of this report. If this is a followup report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if itis, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.

5. If the organization filing the report in item 4 checks "Subawardee," then enter the full name, address, city, state and zip code of the prime federal recipient. Include Congressional District, if known.

6. Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.

7. Enter the federal program name or description for the covered federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate federal identifying number available for the federal action identified in item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the

application/proposal control number assigned by the Federal agency). Include prefixes, e.g., "RFP-DE-90-001".

9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.

10. (a) Enter the full name, address, city, state and zip code of the lobbying registrant under the Lobbying Disclosure Act of 1995 engaged by the reporting entity identified in item 4 to influence the covered Federal action.

    (b) Enter the full names of the individual(s) performing services, and include full address if different from 10 (a). Enter Last Name, First Name, and Middle Initial (MI).

11. The certifying official sign and date the form, print his/her name, title, and telephone number.

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

Exhibit E – Program Terms and Conditions

1.0 Program Terms and Conditions

1.1 Program Terms and Conditions

1.1.1 Governing Law
1.1.2 DHCS Guidance
1.1.3 Contract Interpretation
1.1.4 Assignments, Mergers, Acquisitions
1.1.5 Independent Contractor
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1.1.8 Authority of the State
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1.1.31 Small Business Participation and Disabled Veteran Business Enterprises Reporting Requirements
1.1.32 Conflict of Interest Avoidance Requirements
1.1.33 Guaranty Provision
1.1.34 Priority of Provisions
1.1.35 Additional Incorporated Provisions – Narrative Proposals
1.1.36 Miscellaneous Provisions
1.1.37 Data Sharing

Exhibit E - Program Terms and Conditions

1.1.1 Governing Law

A. Contractor must comply with all applicable federal and State law.

B. All Contract disputes and determinations must be decided under California state law, and federal law, as applicable.

C. The venue and forum for any civil action involving a Contract dispute will be in the Superior Court for the State of California, County of Sacramento.

D. Applicability of the Knox-Keene Act

1) A Contractor who is licensed as a health care service plan pursuant to the Knox-Keene Health Care Service Plan Act of 1975 and its implementing regulations (28 California Code of Regulations (CCR) section 1000, *et seq*.) (KKA) must comply with all applicable provisions of the KKA.

2) A Contractor who is not licensed to operate as a health care service plan pursuant to the KKA must perform all acts and satisfy all requirements under the KKA to the same extent as Contractors who are licensed pursuant to the KKA, except as otherwise expressly provided in this Contract. A Contractor who is not licensed to operate as a health care service plan under the KKA is not required by this Contract to perform or satisfy the following:

a) Any provision of the KKA which requires the submission of a report of any kind to the Department of Managed Health Care (DMHC) or obliges a health care service plan to seek approval from DMHC, including, but not limited to, the Independent Medical Review processes set out in section 1370.4 and Article 5.55 of the KKA;

b) Any provision under Article 3 of the KKA related to licensure; and

c) The provisions set forth in Exhibit K of this Contract. Exhibit K is not an exhaustive or exclusive list, and other provisions of the KKA may also be excluded from the Contract pursuant to this Exhibit E, Subsection 1.1.1 (*Governing Law*) or other provisions of this Contract.

3) Both KKA-licensed Contractors and non-KKA-licensed Contractors are subject to the following provisions:

a) Nothing in this Exhibit E, Subsection 1.1.1.D (*Applicability of Knox-Keene Act*) is intended to relieve Contractor of any other duties or requirements that would otherwise apply; and

b) In the event that a provision of this Contract sets a standard or requirement that is higher or affords a greater benefit or right to a Member than that which the KKA provides, the Contract provisions prevail.

1.1.2 DHCS Guidance

Contractor must comply with all DHCS guidance, including but not limited to All Plan Letters (APLs), Policy Letters (PLs), the California Medicaid State Plan, and the Medi-Cal Provider Manual.

A. APLs and PLs

Contractor must comply with all existing and future APLs and PLs as follows:

1) APLs and PLs existing on the effective date of the Contract will be considered part of the Contract as if fully set forth herein;

2) APLs and PLs issued or revised subsequent to the effective date of the Contract can provide clarification of existing contractual obligations;

3) APLs and PLs issued or revised subsequent to the effective date of the Contract can provide instructions regarding implementation of mandated obligations, including but not limited to implementation of changes in State or federal statutes or regulations, or pursuant to judicial interpretation; and

4) APLs and PLs issued by DHCS pursuant to statutory authority to issue guidance in lieu of regulations will have the same force and effect as regulations and may set forth new obligations.

5) APLs and PLs cited and incorporated by reference into the Contract also include any subsequent revisions to the APL or PL.

B. California Medicaid State Plan

Unless otherwise specified in this Contract, Contractor will comply with all applicable provisions of the California Medicaid State Plan, as amended. In the event there is a conflict between the California Medicaid State Plan and this Contract, the California Medicaid State Plan will control. The California Medicaid State Plan and any amendments thereto, can be viewed at the California's Medicaid State Plan (Title XIX) web page.

C. Medi-Cal Provider Manual

Unless otherwise specified in this Contract, Contractor must comply with all current and applicable provisions of the Medi-Cal Provider Manual. In the event that the Medi-Cal Provider Manual conflicts with this Contract, APLs and PLs, and/or any applicable federal or State laws, the Contract, the APL or PL, or the applicable law will control. The Medi-Cal Provider Manual can be viewed online.

1.1.3 Contract Interpretation

A. Conflict with Law

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

If changes in federal or State law result in a material change to the Contract, the amendment may constitute grounds for termination of this Contract in accordance with Exhibit E, Subsection 1.1.16 (*Termination*). The parties will be bound by the terms of the amendment until the effective date of the termination.

B. Word Usage

Unless the context of this Contract clearly requires otherwise, (a) the plural and singular numbers will each be deemed to include the other; (b) the masculine, feminine, and neuter genders will each be deemed to include the others; (c) "shall," "will," "must," or "agrees" are mandatory, and "may" is permissive; (d) "or" is not exclusive; and (e) "includes" and "including" are not limiting.

C. Ambiguities

If it is necessary to interpret the text of this Contract to address potential ambiguities, all applicable laws may be used as aids in interpreting the Contract. However, DHCS and Contractor agree that any such applicable laws will not be interpreted to create additional contractual obligations upon either DHCS or Contractor, unless such applicable laws are expressly incorporated into this Contract in some section other than this Section. This Contract is the product of mutual negotiation, and if any ambiguities should arise in the interpretation of this Contract, both parties will be deemed authors of this Contract.

D. Unenforceable Provisions

In the event that any provision of this Contract is unenforceable or held to be unenforceable, then DHCS and Contractor agree that all other provisions of this Contract have force and effect and will not be affected thereby.

E. Timeliness

Time is of the essence in this Contract.

F. Entire Agreement

This written Contract, any amendments thereto, and DHCS guidance as identified in Exhibit E, Subsection 1.1.2 (*DHCS Guidance*), will constitute the entire agreement between the parties. No oral representations will be binding on either party unless such representations are put in writing and made an amendment to this Contract.

1.1.4 Assignments, Mergers, Acquisitions

Contractor is prohibited from assigning this Contract, either in whole or in part, without the express written consent of DHCS in the form of a formal written amendment signed by DHCS, Contractor, and the third-party assignee (See also, Exhibit A, Attachment III, Subsection 3.1.2 (*DHCS Approval of Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements).* Contractor must also obtain the express written consent of DHCS prior to entering into a merger or acquisition, whether or not Contractor is the merging party or the acquiring party.

1.1.5 Independent Contractor

Contractor and their employees and agents, in the performance of this Contract, will act in an independent capacity and not as officers or employees or agents of DHCS.

1.1.6 Amendment and Change Order Process

A. General Provisions

The parties recognize that during the term of this Contract, the Medi-Cal managed care program is a dynamic program requiring ongoing changes to its operations and that the scope and complexity of changes will vary widely over the term of this Contract. Contractor must develop a system which has the capability to implement such changes in an orderly and timely manner. This is an essential contract performance obligation.

B. Proposal of Contract Changes

Except for required amendments pursuant to Exhibit E, Subsection 1.3.A (*Contract Interpretation*) should either party, during the life of this Contract, desire a change in this Contract, that change must be proposed in writing to the other party. The other party must acknowledge receipt of the proposal within ten calendar days of receipt of the proposal. The party proposing any such change will have the right to withdraw the proposal any time prior to acceptance or rejection by the other party. Any proposal must set forth an explanation of the reason and basis for the proposed change and the text of the desired amendment to this Contract.

1) Regardless of the party desiring the change, DHCS will be responsible for drafting the proposed amendment and providing it to Contractor for review and comment prior to the language being finalized and submitted to CMS for approval.

2) DHCS will determine Contractor’s Capitation Payment rates for each Rating Period and, as necessary, subsequent revised rates for the same Rating Period, as stated in Exhibit B, Subsection 1.1.5 (*Determination and Redetermination of Capitation Payment Rates*).

C. Implementation of Contract Capitation Payments

DHCS may, at any time within the general scope of this Contract and by written notice, implement Capitation Payment rates through amendments to the Contract upon approval from CMS. Capitation Payment rates that are tied to proposed changes to the terms or requirements of the Contract effective within the Rating Period will be included in an amendment to the Contract.

D. Contractor's Obligation to Implement

Notwithstanding approval by CMS of proposed changes to this Contract, Contractor will comply with changes mandated by DHCS. In the case of

changes mandated by regulations, statutes, federal guidelines, or judicial interpretation, Contractor must immediately begin implementation of any change proposed in an amendment to this Contract or through an APL. If DHCS implements an amendment or APL, Contractor must implement the required changes and accept current Capitation Payments as stated in Exhibit B, Section 1.5 (*Determination and Redetermination of Capitation Payment Rates*) while discussions relevant to any Capitation Payment rate adjustment, if applicable, are taking place.

1.1.7 Delegation of Authority

DHCS intends to implement this Contract through a single administrator, called the "DHCS Contracting Officer." The Director will appoint its DHCS Contracting Officer. The DHCS Contracting Officer, under the direction of the Director and on behalf of DHCS, will make all determinations and take all actions as are appropriate under this Contract, subject to the limitations of applicable federal and State laws and regulations. The DHCS Contracting Officer may delegate their authority to act to an authorized representative through written notice to Contractor.

Contractor will designate a single administrator (Contractor's Representative) to implement this Contract. Contractor's Representative, on behalf of Contractor, will make all determinations and take all actions as are appropriate to implement this Contract, subject to the limitations of the Contract, federal and State laws and regulations. Contractor's Representative may delegate their authority to act to an AR through written notice to the DHCS Contracting Officer. Contractor's Representative will be empowered to legally bind Contractor to all agreements reached with DHCS.

Contractor will designate Contractor’s Representative in writing and must notify the DHCS Contracting Officer in accordance with Exhibit E, Subsection 1.1.12 (*Notices*).

1.1.8 Authority of the State

A. Subject to federal and State laws and regulations, DHCS has sole authority to establish, define, and determine the reasonableness, necessity, level, and scope of Covered Services available under the Medi-Cal managed care program administered through this Contract or coverage for such benefits, or the eligibility of Members or Providers to participate in the Medi-Cal managed care program.

B. DHCS has sole authority to establish or interpret policy and its application related to administration of the Medi-Cal program.

C. Contractor must not make any limitations, exclusions, or changes in benefits or benefit coverage; any changes in definition or interpretation of benefits; or any changes in the administration of the Contract related to the scope of benefits, allowable coverage for those benefits; or eligibility of Members or Providers to participate in the program, without the express, written direction or approval of the DHCS Contracting Officer.

1.1.9 Fulfillment of Obligations

Contractor must not waive any covenant, condition, duty, obligation, or undertaking contained in or made a part of this Contract except by written agreement of the parties. Forbearance or indulgence in any other form or manner by either party in any regard whatsoever will not constitute a waiver of the covenant, condition, duty, obligation, or undertaking to be kept, performed or discharged by the party to which the same may apply. Until performance or satisfaction of all covenants, conditions, duties, obligations, and undertakings is complete, the other party will have the right to invoke any remedy available under this Contract, or under law, notwithstanding such forbearance or indulgence.

1.1.10 Obtaining DHCS Approval

A. DHCS Approval of Deliverables Prior to Commencement of Operations

Prior to commencement of operations, Contractor must obtain written approval from DHCS for all deliverables, including but not limited to protocols, policies, and procedures, set forth in Exhibit A, Attachment III, Article 7.0 (*Operations Deliverables and Requirements*).

B. DHCS Approval of Protocols, Policies, and Procedures

In addition to the deliverables identified in Exhibit A, Attachment III, Article 7.0 (*Operations Deliverables and Requirements*) of this Contract, DHCS reserves the right to review and approve or disapprove Contractor's protocols, policies, and procedures. DHCS may, from time to time, request changes to Contractor's existing protocols, policies, and procedures. DHCS will issue such requests through APLs or other similar instructions. The deliverables, protocols, policies, and procedures referenced in this Exhibit E, Subsections 1.1.10.A and B (*Obtaining DHCS Approval*), will be subject to the DHCS approval process set forth in Exhibit E, Subsection 1.1.10.C (*Obtaining DHCS Approval*), below.

C. DHCS Approval Process

Within 60 calendar days of receipt, DHCS will make all reasonable efforts to approve in writing Contractor's deliverables, protocols, policies, and procedures; provide Contractor with a written explanation of disapproval;

or provide a written estimated date of completion of DHCS' review process.

If DHCS does not complete its review of submitted materials within 60 calendar days of receipt, or within the estimated date of completion of DHCS review, Contractor may elect to implement or use the materials at Contractor's sole risk and subject to possible subsequent disapproval by DHCS. This Exhibit E, Subsection 1.1.10.C (*Obtaining DHCS Approval*) will not be construed to imply DHCS approval of any materials that have not received written DHCS approval. This Section will not apply to Subcontractor Agreements, Downstream Subcontractor Agreements, or Network Provider Agreements subject to DHCS approval in accordance with Exhibit A, Attachment III, Subsection 3.1.2 (*DHCS Approval of Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements*).

1.1.11 Certifications

A. For each data submission required by 42 Code of Federal Regulations (CFR) section 438.604, Contractor must comply with the requirements of 42 CFR section 438.606 and APL 17-005. Contractor must submit its certification of compliance concurrently with the submission of its data, documentation or information pursuant to 42 CFR section 438.606(c). Contractor's certification(s) must be certified by Contractor's Chief Executive Officer (CEO); Chief Financial Officer (CFO); or an individual who reports directly to the CEO or CFO with delegated authority to sign for the CEO or CFO. Contractor's CEO or CFO is solely responsible for the truth, accuracy and completeness of Contractor's certification.

1) Contractor's data submissions must be in a form and manner specified by DHCS:

a) Encounter Data as set forth in 42 CFR section 438.604(a)(1); and

b) Data used by the State to certify actuarial soundness of Capitation Payment rates as set forth in 42 CFR section 438.604(a)(2).

2) Medical Loss Ratio (MLR) data as set forth in 42 CFR section 438.604(a)(3);

3) Financial data regarding provisions against risk of insolvency as set forth in 42 CFR section 438.604(a)(4);

4) Documentation described in 42 CFR section 438.207(b) used to certify compliance with this Contract's requirements for accessibility and availability of services, including Network adequacy;

5) Contractor's information on ownership and control, including its Subcontractors, Downstream Subcontractors, and Network Providers, as set forth in 42 CFR sections 438.608(c)(2), 438.602(c), and 455.104;

6) The annual report of overpayment recoveries as required in 42 CFR section 438.608(d)(3);

7) Network Data as required in Exhibit A, Attachment III, Subsection 2.1.4 (*Network Provider Data Reporting*);

8) Documentation confirming compliance with this Contract's interoperability requirements and APL 22-026 that is certified by Contractor's CEO or CFO and in accordance with submission requirements in APL 17-005; and

9) Any other data, documentation, or information requested by DHCS relating to the performance of Contractor's obligations under this Contract.

B. The Contractor Certification Clauses (CCC) contained in the Department of General Services form document CCC 04/2017 are hereby incorporated by reference and made a part of this Contract by this reference as if attached hereto.

1.1.12 Notices

All notices to be given under this Contract must be in writing and are deemed given when sent certified mailed or electronic mail (email) to DHCS or Contractor. DHCS and Contractor will designate email addresses for notices sent via email. Notices sent certified mail must be addressed to the following DHCS and Contractor addresses:

California Department of Health Care Services	[Contractor's Name]
Managed Care Operations Division	
Attn: DHCS Contract Manager	Attn: Contractor Representative
MS 4407	
P.O. Box 997413	[Mailing Address]
Sacramento, CA 95899-7413	[City, State Zip Code]

1.1.13 Term

A. The Contract will be effective January 1, 2024, and will continue in full force and effect through December 31, 2026, subject to Exhibit B, Subsection 1.1.1 (*Budget Contingency Clause*), CMS waiver approval, and Exhibit D(f), Section 9 (*Federal Contract Funds*).

B. If Contractor has not already commenced operations, the term of this Contract consists of the following three periods:

1) The Implementation Period;

2) The Operations Period; and

3) The Phaseout Period.

C. The Operations Period will commence at the conclusion of the Implementation Period, subject to DHCS acceptance of Contractor's readiness to begin the Operations Period. The term of the Operations Period is subject to the termination requirements of Exhibit E, Subsections 1.1.16 (*Termination*) and 1.1.19 (*Sanctions*), and subject to the limitation provisions of Exhibit B, Subsection 1.1.1 (*Budget Contingency Clause*).

D. The Phaseout Period will commence on the date the Operations Period or Contract extension ends. The Phaseout Period will extend until all activities required during the Phaseout Period for each Service Area are fully completed to the satisfaction of DHCS, in its sole discretion.

E. If Contractor has commenced operations as of the effective date of this Contract, the term of the Contract consists of the Operations Period and the Phaseout Period. The term of the Operations Period is subject to the termination requirements of Exhibit E, Subsections 1.1.16 (*Termination*) and 1.1.19 (*Sanctions*) below and subject to the limitation requirements of Exhibit B, Subsection 1.1.1 (*Budget Contingency Clause*).

1.1.14 Service Area

The Service Area covered under this Contract includes:

XXXXXXX County/ies

Unless otherwise specified in this Contract, all Contract provisions apply separately to each Service Area. This Contract may expire for some Service Areas and remain in effect for others with each Service Area having its own Operations and Phaseout Periods.

1.1.15 Contract Extension

DHCS has the exclusive option to extend the term of the Contract for any Service Area during the last 12 months of the Contract, as determined by the original expiration date or by a new expiration date if an extension option has been exercised. Contractor will be given at least nine months prior written notice of DHCS' decision on whether it will exercise this option to extend the Contract for each Service Area.

Contractor will provide written notification to DHCS of its intent to accept or reject the Contract extension within five Working Days of the receipt of the notice from DHCS.

1.1.16 Termination

A. DHCS-Initiated Terminations

1) Mandatory Termination

a) DHCS must terminate this Contract in the event of any of the following:

i. The Secretary of the U.S. Department of Health & Human Services (U.S. DHHS) determines that Contractor does not meet the requirements for participation in the Medicaid program (42 United States Code (USC) section 1396);

ii. DMHC finds that Contractor no longer qualifies for licensure under the KKA (Health and Safety Code (H&S) section 1340 *et seq.*), if licensure is required; or

iii. The Director determines the health and welfare of Members is jeopardized by continuation of the Contract.

b) Termination pursuant to Subsection 1.16.A.1 (*Mandatory Termination*) will be effective immediately. Termination under this Section 1.16.A does not relieve Contractor of its obligations under Exhibit E, Section 1.17 (*Phaseout Requirements*).

2) Termination for Cause

a) DHCS may terminate this Contract and be relieved of any payments should Contractor fail to perform the requirements of this Contract. In the event of such termination, DHCS may

proceed with providing the services required under this Contract in any manner deemed proper by DHCS. All costs to the State will be deducted from any sum due Contractor under this Contract and the balance, if any, will be paid to Contractor upon demand.

b) DHCS will provide Contractor with at least 60 calendar days' notice prior to the effective date of termination, unless Potential Member harm requires a shorter notice period. Contractor agrees that this notice provision is reasonable. Termination under this Subsection does not relieve Contractor of its obligations under Exhibit E, Subsection 1.1.17 (*Phaseout Requirements*).

c) DHCS will terminate this Contract under this Subsection, pursuant to the provisions of W&I section 14197.7 and 22 CCR section 53873.

d) Contractor may dispute termination decisions under this Exhibit E, Subsection 1.1.16 (*Termination*), through the dispute resolution process pursuant to Exhibit E, Subsection 1.1.21 (*Contractor's Dispute Resolution Requirements*).

3) Permissive Termination

Following a merger or acquisition involving Contractor in which Contractor did not obtain DHCS' express written consent pursuant to Exhibit E, Subsection 1.1.4 (*Assignments, Mergers, Acquisitions*), whether Contractor is the merging party or the acquiring party, DHCS, in its sole discretion, retains the right to terminate this Contract.

a) DHCS will provide written notice of termination to Contractor at least 60 calendar days prior to the effective date of termination.

b) Contractor must fully perform all Contract obligations prior to the effective date of termination. Contractor will not be entitled to additional reimbursement for the services provided following notice of termination until the termination effective date.

c) Termination under this Subsection does not relieve Contractor of its Phaseout Requirement obligations as stated in Exhibit E, Subsection 1.1.17 (*Phaseout Requirements*).

4) Termination Without Cause

a) DHCS may terminate this Contract and award a new contract for one or more of the Service Areas to another Medi-Cal managed care plan during one of the amendment periods as described in Exhibit E, Subsection 1.1.15 (*Contract Extension*).

b) Notwithstanding any other provision in this Contract, DHCS may terminate this Contract in whole or in part at any time at DHCS' sole discretion.

c) DHCS will notify Contractor of termination under this Exhibit E, Subsection 1.1.16 (*Termination*) at least six months prior to the effective date of termination to allow for all Phaseout Requirements to be completed.

B. Contractor-Initiated Terminations

Contractor may only terminate this Contract under one or more of the following circumstances:

1) For Rating Periods subsequent to Calendar Year 2024, if Contractor does not accept the Capitation Payment rates determined by DHCS, or if DHCS decides to negotiate the Capitation Payment rates and the parties do not agree on the rates; or

2) When a change in contractual obligations is created by a State or federal change in the Medi-Cal program or a lawsuit that substantially alters the financial assumptions and conditions under which Contractor entered into this Contract, such that Contractor can demonstrate to the satisfaction of DHCS that it cannot remain financially solvent through the term of the Contract, the following will apply:

a) Contractor will submit a detailed written financial analysis to DHCS supporting its conclusions that it cannot remain financially solvent. At DHCS' request, Contractor will submit or otherwise make available to DHCS all of Contractor's financial work papers, financial reports, financial books and other records, bank statements, computer records, and any other information requested by DHCS to evaluate Contractor's financial analysis;

b) DHCS and Contractor may negotiate an earlier termination date than the termination date set forth in this Subsection 1.16.B, if Contractor can demonstrate to the satisfaction of DHCS that it cannot remain financially solvent until the termination date that would otherwise be established under this Subsection;

c) Contractor must provide at least a six-month written notice of termination under this Exhibit E, Subsection 1.1.16 (*Termination*). The effective date of termination will be December 31 of the year in which Contractor gives notice, unless the date of notice is less than six months before December 31. In that event, termination under this Exhibit E, Subsection 1.1.16 (*Termination*) will be effective no earlier than December 31 of the following year.

d) Termination under these circumstances does not relieve Contractor of its obligations as stated in Exhibit E, Subsection 1.1.17 (*Phaseout Requirements).*

C. Termination of Obligations

Contractor's obligations to provide Covered Services under this Contract or under any Contract extension terminate on the date the Operations Period ends.

D. Notice to Members of Transfer of Care

Following notice of termination by either DHCS or Contractor, notice to the Member will be directed by DHCS. Contractor will not send any notices to its Members regarding the termination unless it receives prior approval from DHCS.

1.1.17 Phaseout Requirements

A. DHCS will retain Capitation Payment for each Service Area from Contractor's Capitation Payment for the last four months of the Operations Period for each Service Area, or Contractor must provide a performance bond to DHCS of an equal amount, until all Directive Payment Initiatives and Supplemental Payments have been calculated and processed by DHCS and all activities required during the Phaseout Period for each Service Area are fully completed to the satisfaction of DHCS, in its sole discretion.

Upon DHCS' processing of all Directive Payment Initiatives and Supplemental Payments and the completion of all Phaseout Period

activities for each Service Area, the withhold will be paid to Contractor or the performance bond will be released. If Contractor fails to meet any requirements of the Phaseout Period for each Service Area, DHCS will deduct the costs of the remaining activities from the withhold amount and continue to withhold payment until all activities are completed.

B. The objective of the Phaseout Period is to ensure that, in connection with the expiration or termination of this Contract, Contractor ensures an orderly transfer of necessary data and history records to DHCS or to a successor Medi-Cal managed care plan. Contractor will not provide services to Members during the Phaseout Period.

Within no later than 90 calendar days prior to termination or expiration of this Contract and through the Phaseout Period for each Service Area, Contractor must assist DHCS in the transition of Members and in ensuring, to the extent possible, continuity of Member-Provider relationships. In doing this, Contractor will make available to DHCS, without additional compensation, copies of each Member's Medical Records and files, and any other pertinent information, including information maintained by any Subcontractor, Downstream Subcontractor, or Network Provider, necessary to provide effected Members with case management and continuity of care. In no circumstances will a Medi-Cal Member be billed for this activity.

C. Phaseout for this Contract includes processing, payment, and monetary and data reconciliations necessary regarding Provider claims for Covered Services.

1) Phaseout for this Contract includes the completion of all financial and reporting obligations of Contractor. Contractor will remain liable for the processing and payment of invoices and other claims for payment for Covered Services and other services provided to Members prior to the expiration or termination of this Contract. Contractor must timely submit to DHCS all reports required in Exhibit A, Attachment III, Article 7.0 (*Operations Deliverables and Requirements*) for the period from the last submitted report through the expiration or termination date, and Contractor will be obligated to cooperate with DHCS with regard to the reconciliation of Contractor's Encounter Data Reporting and Network Provider Data Reporting for up to two years following the expiration or termination of this Contract.

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

D. The Phaseout Period will commence on the date the Operations Period of the Contract or Contract extension ends. Phaseout related activities are non-payable obligations and services.

1.1.18 Indemnification

A. As a condition of entering into this Contract, Contractor agrees to indemnify, defend and hold harmless the State, DHCS and its officers, agents, and employees from any and all claims and losses accruing or resulting from any and all Network Providers, Subcontractors, Downstream Subcontractors, suppliers, laborers, and any other person, firm, or corporation furnishing or supplying work services, materials, or supplies in connection with the performance of this Contract, and from any and all claims and losses accruing or resulting to any person, firm or corporation who may be injured or damaged by Contractor in the performance of this Contract.

B. Contractor further agrees to indemnify, defend, and hold harmless the State, DHCS and its officers, agents, and employees from any and all claims and losses, any and all attorneys' fees and costs, judgments, damages, and any Administrative Costs incurred by DHCS or a Member from any and all litigation, arbitration or mediation resulting directly, indirectly, or arising out of Contractor's denial, delay, or modification of requested Covered Services.

C. Contractor further agrees to indemnify, defend, and hold harmless the State, DHCS and its officers, agents and employees from any and all claims and losses, any and all attorneys' fees and costs, including DHCS' defense costs, judgments, damages, any Administrative Costs incurred from claims that Contractor violated the Telephone Consumer Protection Act of 1991, 47 USC section 227 *et seq*., and/or related Federal Communications Commission regulations in the performance of this Contract.

D. Contractor further agrees to indemnify, defend and hold harmless the State, DHCS and its officers, agents and employees from any and all claims and losses, any and all attorneys' fees and costs, judgments, damages, any Administrative Costs incurred to the extent DHCS is required to provide notice to affected Members and Potential Members, and any other costs associated with any actual or alleged breach, by Contractor and any vendor, Subcontractor, Downstream Subcontractor, or Network Provider Contractor contracts with in the performance of this Contract, of the following statutes and regulations: the of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), the Health Information Technology for Economic and Clinical

Health Act, Public Law 111-005 (“the HITECH Act"), 42 USC section 17921 *et seq.*, and their implementing privacy and security regulations at 45 CFR parts 160 and 164 and the Information Practices Act, and Civil Code (CC) section 1798 *et seq.* by Contractor.

E. DHCS is authorized to withhold any and all attorneys’ fees and costs, judgments, damages, any Administrative Costs incurred pursuant to this indemnification agreement, from Contractor’s next Capitation Payment or any other method to recoup DHCS’ costs from Contractor.

1.1.19 Sanctions

A. Contractor is subject to sanctions and civil penalties for the specific conduct set forth in 42 CFR sections 438.700, 438.702, 438.704, 438.706, and 438.708. DHCS is also authorized to impose additional sanctions on Contractor pursuant to 42 CFR section 438.702(b) as set forth in W&I section 14197.7, APL 25-007, and any other applicable law.

B. Monetary sanctions imposed pursuant to W&I section 14197.7 may be separately and independently assessed and may also be assessed for each day Contractor fails to correct an identified deficiency. For deficiencies that impact Members and Potential Members, each impacted Member or Potential Member constitutes a separate violation for the purposes of imposing a monetary sanction.

C. Good cause for imposing monetary sanctions includes but is not limited to a breach of this Contract, a violation of a legal obligation (including, but not limited to, obligations imposed by statute, regulation, APL, PL, or other DHCS Guidance), a finding of deficiency that results in an improper denial or delay in the delivery of health care services, potential endangerment of a Member’s care, disruption in Contractor’s Network, failure to approve continuity of care for a Member, failure to timely and correctly reimburse claims, or a delay in required reporting to DHCS. Further grounds for imposing sanctions include, but are not limited to, those set forth in 42 CFR section 438.700 et seq., W&I section 14197.7, and APL 25-007.

D. DHCS may identify findings of noncompliance or good cause through any means, including, but not limited to, findings in audits; investigations; contract compliance reviews; Quality Improvement System monitoring; routine monitoring; facility site surveys; Encounter Data submissions; Grievances and Appeals; Network adequacy reviews; assessments of timely access requirements; reviews of utilization data; health plan rating systems; State Hearing decisions; IMR decisions; complaints from Members, Providers, Network Providers, Subcontractors, Downstream Subcontractors, other stakeholders, or whistleblowers; and Contractor’s self-disclosures.

E. Sanctions in the form of denial of payments provided for under this Contract for new Members will be taken, when and for as long as, payment for those Members is denied by CMS under 42 CFR section 438.730.

F. DHCS may also impose nonmonetary sanctions as set forth in 42 CFR section 438.700 et seq., W&I section 14197.7, APL 25-007, and any other applicable law.

G. DHCS is not required to impose a Corrective Action plan on Contractor before imposing any of the sanctions set forth in this Section or in State and federal law.

H. DHCS may impose sanctions in addition to any monetary damages recovered pursuant to Exhibit E, Subsection 1.1.20 (*Liquidated Damages*).

1.1.20 Liquidated Damages

A. If Contractor breaches this Contract, DHCS will be entitled to all legal and equitable remedies available under the law, including monetary damages in the form of actual, consequential, direct, indirect, special, and/or liquidated damages.

B. Contractor agrees that any breach of this Contract, including but not limited to a breach due to Contractor's delay in implementing new program requirements or plan readiness requirements or Contractor's failure to meet its Quality or Network Adequacy obligations, may result in damage to the State or DHCS that is difficult to quantify. In the event of such a breach, Contractor agrees that the Director is authorized to impose liquidated damages on Contractor in the amount of $25,000 for each separate and distinct breach in addition to liquidated damages in the amount of $25,000 for each day Contractor fails to remedy the breach, which the Parties agree bears a reasonable relationship to the range of actual damages the Parties anticipate would flow from such a breach.

C. Contractor acknowledges that DHCS' authority to impose monetary sanctions and other intermediate sanctions pursuant to 42 CFR section 438.700 *et seq*. and W&I section 14197.7, as set forth in Exhibit E, Subsection 1.1.19 (*Sanctions*)*,* is separate and distinct, and that DHCS may recover damages for Contractor's breach, including liquidated damages, in addition to any sanctions imposed under Exhibit E, Subsection 1.1.19 *(Sanctions).*

1.1.21 Contractor's Dispute Resolution Requirements

Contractor must comply with and exhaust the requirements of this Section when it initiates a contract dispute with DHCS. This Exhibit E, Subsection 1.1.21 (*Contractor's Dispute Resolution Requirements*) does not apply to challenges to sanctions as described in Exhibit E, Subsection 1.1.19 *(Sanctions)* liquidated damages as described in Exhibit E, Subsection 1.1.20 *(Liquidated Damages)*, or any other contract compliance action initiated by DHCS. Contractor's filing of a Notice of Dispute, as defined in Paragraph B of this Section, does not preclude DHCS from withholding or recouping the value of the amount in dispute from Contractor, or from offsetting the amount in dispute from subsequent Capitation Payment(s).

A. Resolution of Dispute by Negotiation

Contractor agrees to make best efforts to resolve all alleged contractual issues by negotiation and mutual agreement at the DHCS Contracting Officer level before appealing to the DHCS Office of Administrative Hearings and Appeals (OAHA). Contractor must exhaust OAHA's appeal process before filing a writ in Sacramento County Superior Court. During the negotiations to resolve Contractor's issues, DHCS and Contractor may agree, in writing, to an extension of time for continuing negotiations to resolve Contractor's dispute before the decision of the DHCS Contracting Officer is issued.

B. Notice of Dispute

Within 30 calendar days from the date that the alleged dispute arises or otherwise becomes known to Contractor, Contractor must serve a written notice of dispute to the DHCS Contract Manager. Contractor's failure to serve its notice of dispute within 30 calendar days from the date the alleged dispute arises or otherwise becomes known to Contractor constitutes a waiver of all issues raised in Contractor's notice of dispute.

Contractor's notice of dispute must include, based on the most accurate information and substantiating documentation available to Contractor, the following:

1) That the dispute is subject to the procedures in this Exhibit E, Subsection 1.1.21 (*Contractor's Dispute Resolution Requirements*);

2) The date, nature, and circumstances of the alleged conduct that is subject of the dispute;

3) The names, phone numbers, functions, and conduct of every Subcontractor, Downstream Subcontractor, Network Provider, DHCS/State official or employee involved in or knowledgeable of the alleged issue(s) that is the subject of the dispute;

4) The identification of any substantiating documents and the substance of any oral communications that are relevant to the alleged conduct;

5) Copies of all substantiating documentation and any other evidence attached to its notice of dispute;

6) The factual and legal bases supporting Contractor's notice of dispute;

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

8) Contractor's desired remedy.

After Contractor submits its notice of dispute with all accurate available substantiating documentation, Contractor must comply with 22 CCR section 53851(d) and diligently continue performance of its obligations under this Contract, including compliance with contract requirements that are the subject of, or related to, Contractor's notice of dispute.

If Contractor requests and DHCS agrees, Contractor's notice of dispute may be decided by an alternate dispute officer (ADO). DHCS will designate an ADO who was not directly involved in the alleged conduct that prompted Contractor's notice of dispute.

Any appeal of the DHCS Contracting Officer's decision to OAHA or a writ seeking review of OAHA's decision in Sacramento County Superior Court is limited to the issues and arguments set forth and properly documented in Contractor's notice of dispute, that were not waived or resolved.

C. Timeframes

The DHCS Contracting Officer or ADO will have 90 calendar days to review Contractor's initial notice of dispute and available substantiating documentation and issue a decision unless there is a written agreement between DHCS and Contractor to extend that time. If the DHCS Contracting Officer or ADO determines that additional substantiating documentation is required, they will provide Contractor with a written request identifying the issue(s) requiring additional supporting documentation. Contractor must provide that additional substantiating documentation no later than 30 calendar days from receipt of the request.

Unless Contractor and the DHCS Contracting Officer or ADO agree to an extension of time, in writing, Contractor's failure to provide additional

substantiating documentation, or otherwise notify the DHCS Contracting Officer or ADO that no additional documents exist, within 30 calendar days from the request, constitutes Contractor's waiver of all issues raised in Contractor's notice of dispute.

Issues raised by Contractor in the notice of dispute will be decided by the DHCS Contracting Officer or the ADO within 90 calendar days from receipt of Contractor's substantiating documentation or within 60 calendar days from receipt of all additionally requested substantiating documentation from Contractor, whichever is later.

D. The DHCS Contracting Officer's or ADO's Decision

1) If the DHCS Contracting Officer or the ADO finds in favor of Contractor, they may:

a) Correct the conduct which prompted Contractor's notice of dispute; or

b) Require performance of the disputed conduct and, if there is a cost impact sufficient to constitute a material change in obligations pursuant to the payment provisions under Exhibit B, Subsection 1.1.1 (*Budget Contingency Clause*), direct DHCS to comply with that Exhibit. In the event of such a finding DHCS will not owe interest on any underpayment found due and owing pursuant to the notice of dispute.

2) If DHCS' Contracting Officer or the ADO denies Contractor's notice of dispute, they are authorized to direct the manner of Contractor's future contractual performance.

E. Appeal of the DHCS Contracting Officer's or ADO's Decision

1) Contractor will have 30 calendar days following the receipt of DHCS Contracting Officer's or ADO's decision to appeal the decision to the Director, through OAHA. All of Contractor's appeals will be governed by H&S section 100171, except Government Code (GC) section 11511 relating to depositions will not apply. The venue of OAHA appeals will be in Sacramento.

2) All of Contractor's appeals must be in writing and must be filed with OAHA and a copy sent to the Chief Counsel of DHCS and DHCS Contract Manager. Contractor's appeal will be deemed filed on the date it is received by OAHA. Contractor's appeal must specifically set forth the unresolved issues that remain in dispute and issues that have not been waived because of Contractor's failure to

provide all substantiating documentation to DHCS, as specified in Exhibit E, Subsection 1.1.21 (*Contractor's Dispute Resolution Requirements*). Additionally, Contractor's appeal is solely limited to the issues raised in its notice of dispute that have not been resolved or waived.

3) Contractor has the burden of proof of demonstrating that its position is correct and must show by a preponderance of evidence that:

   a) DHCS acted improperly such that it breached this Contract; and

   b) Contractor sustained a cost impact directly related to DHCS' breach.

4) OAHA's jurisdiction is limited to issues and arguments raised in notice of dispute that were not waived either by the untimely filing of the notice of dispute or statement of disputed issues, or by Contractor's failure to provide all requested substantiating documentation requested by DHCS Contracting Officer or ADO or otherwise resolved by Contractor and DHCS.

5) Contractor's failure to timely appeal the decision to OAHA constitutes a waiver by Contractor of all issues raised in Contractor's notice of dispute. This waiver of claims also precludes the filing of a writ in Sacramento Superior Court, or any other court.

F. No Obligation to Pay Interest

If Contractor prevails on its notice of dispute pursuant to a DHCS Contracting Officer's or ADO's decision, an OAHA decision, or an order or decision issued by any State or federal court, including any State or federal court of appeal, or any order, decision, opinion, or award issued in any other forum, DHCS will not be required to pay interest on any amounts found to be due or owing to Contractor arising out of the notice of dispute.

G. Contractor's Duty to Perform

Contractor must comply with all requirements of 22 CCR section 53851(d) and all obligations under this Contract, including continuing Contract requirements that are the subject of, or related to, Contractor's notice of dispute until there is a final decision from the DHCS Contracting Officer, the ADO or a decision on an appeal in Sacramento County Superior Court.

H. Waiver of Claims

Contractor waives all claims or issues if it fails to timely submit a notice of dispute with all substantiating documents within the timeframes noted in Subsection 1.1.21.C, above. Contractor also waives all claims or issues set forth in its notice of dispute if it fails to timely submit all additional substantiating documentation within 30 calendar days of the DHCS Contracting Officer's or ADO's request, or if it fails to timely appeal the DHCS Contracting Officer's or ADO's decision in the manner and within the time specified in this Subsection 1.1.21. Contractor's waiver includes all damages whether direct or consequential in nature.

1.1.22 Inspection and Audit of Records and Facilities

A. Recordkeeping Requirements

1) Records to be Maintained

Contractor must maintain all records and documents necessary to disclose how Contractor discharges its obligations under this Contract. These records and documents will disclose the quantity of Covered Services provided under this Contract, the quality of those services, the manner and amount of payment made for those services, the persons eligible to receive Covered Services, the manner in which Contractor administered its daily business, and the cost thereof.

Contractor must maintain all working papers, reports submitted to (DHCS, DMHC, Division of Medi-Cal Fraud & Elder Abuse (DMFEA), United States Department of Health & Human Services (U.S. DHHS), and United States Department of Justice (US DOJ), financial records, books of account, Medical Records, prescription files, laboratory results, Subcontractor Agreements, Downstream Subcontractor Agreements, and Network Provider Agreements, information systems and procedures, and any other documentation pertaining to medical and non-medical services rendered to Members.

In addition, and in accordance with 42 CFR section 438.3(u), Contractor must retain the following information for no less than ten years and allow auditing entities to inspect and audit:

a) Member Grievance and Appeal records as required in 42 CFR section 438.416;

b) Base data as defined in 42 CFR section 438.5(c);

c) MLR reports as required in 42 CFR section 438.8(k); and

d) Data, information, and documentation specified in 42 CFR sections 438.604, 438.606, 438.608, and 438.610.

2) Records Retention Period

Notwithstanding any other records retention time period set forth in this Contract, Contractor must maintain all records and documents described in this Exhibit E, Subsection 1.1.22 (*Inspection and Audit of Records and Facilities*) for a minimum of ten years from the final date of the Phaseout Period or from the date of completion of any audit, whichever is later, in accordance with 42 CFR sections 438.3(h) and (u) and 438.230(c).

B. Right to Audit and Inspect Records and Facilities

1) Authorized Agencies

Contractor agrees that the following agencies, including but not limited to, DHCS, the Centers for Medicare & Medicaid Services (CMS), U.S. DHHS, U.S. DHHS Office of the Inspector General, the Comptroller General of the United States, US DOJ, DMFEA, DMHC, the External Quality Review Organization (EQRO) contractor, and all other agencies authorized under State and federal law (authorized agencies), and their duly authorized representatives or designees, will have the right to audit and inspect the records and documents in the form or manner in which the authorized agencies request, and facilities of Contractor, and its Subcontractors, Downstream Subcontractors, and Network Providers.

2) Right to Audit and Inspect at Any Time

DHCS, and its designees, and other authorized agencies and their designees, may, at any time, inspect and audit any and all records, documents, contracts, computers, or other electronic systems maintained by Contractor, and its Subcontractors, Downstream Subcontractors, and Network Providers in the form or manner in which the authorized agencies request, and may, at any time, inspect the premises, facilities, and equipment pertaining directly or indirectly to the delivery of Medi-Cal services pursuant to 42 CFR sections 438.3(h) and (u) and 438.230(c), and other applicable State and federal law.

3) Scope of Inspection

DHCS and other authorized agencies may, at any time, audit, inspect, and monitor, Contractor, and its Subcontractors, Downstream Subcontractors, and Network Providers, to assure compliance with any provision of this Contract; evaluate the quality, appropriateness, and timeliness of services performed under this Contract; and for any other reasonable purpose.

Upon request, and through the end of the records retention period specified in Exhibit E, Subsection 1.1.22.A.2 (*Inspection and Audit of Records and Facilities*), Contractor must furnish any record, or copy of it, to DHCS or any other auditing entity listed in this Exhibit E, Subsection 1.1.22 (*Inspection and Audit of Records and Facilities*), at Contractor's sole expense.

4) Right to Audit and Inspect Exists for Ten Years

The right to audit and inspect under this this Exhibit E, Subsection 1.1.22 (*Inspection and Audit of Records and Facilities*) exists for ten years from the final date of the Contract Phaseout Period or from the date of completion of any audit, whichever is later, in accordance with 42 CFR sections 438.3(h) and (u) and 438.230(c).

5) Additional Facility Inspection Rights

In addition to Exhibit D(f), Section 8 (*Site Inspection*) in order to ensure compliance with this Contract, and for any other reasonable purpose, Contractor agrees to the following:

a) DHCS, and its authorized representatives and designees, and authorized agencies, and their authorized representatives and designees, will have the right to access the premises and facilities of Contractor, and the premises and facilities of its Subcontractors, Downstream Subcontractors, and Network Providers, with or without notice, including, but not limited to, the management information systems operations site or such other places where duties and obligations under the Contract are performed.

b) Staff designated by DHCS, and the designated staff of other authorized agencies, must be provided access to security areas of all Contractor, and its Subcontractors, Downstream Subcontractors,' and Network Providers, . Contractor must provide, and must require any and all of its Subcontractors,

Downstream Subcontractors, and Network Providers to provide, reasonable cooperation and assistance to auditing representatives in the performance of their duties.

c) DHCS may conduct unannounced inspections and audits of the premises and facilities of Contractor, and its Subcontractors, Downstream Subcontractors, and Network Providers, selected at DHCS' sole discretion, to verify compliance of these sites with DHCS requirements.

1.1.23 Confidentiality of Information

In addition to Exhibit D(f), Section 14 (*Confidentiality of Information*), Contractor also agrees to the following duties and responsibilities with respect to confidentiality of information and data:

A. Notwithstanding any other provision of this Contract, names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with 42 CFR section 431.300 *et seq.*, W&I section 14100.2, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members will be protected by Contractor.

Contractor may release Medical Records in accordance with applicable law pertaining to the release of this type of information. Contractor is not required to report to DHCS requests for Medical Records made in accordance with applicable law, unless the law requires such reporting.

B. With respect to any identifiable information obtained by Contractor, or its Subcontractors, Downstream Subcontractors, or Network Providers, concerning a Member under this Contract, Contractor will ensure the following:

1) Any such information will not be used for any purpose other than carrying out the express terms of this Contract;

2) All requests for disclosure of such information will be promptly transmitted to DHCS, except requests for Medical Records in accordance with applicable law;

3) Any such information will not be disclosed, except as otherwise specifically permitted by this Contract, to any party other than DHCS without DHCS' prior written authorization specifying that the information is releasable under 42 CFR section 431.300 *et seq.*, W&I section 14100.2, and regulations adopted thereunder; and

4) At the termination of this Contract, the return all such information to DHCS or maintain such information as directed by DHCS.

C. Contractor will have provisions in its Subcontractor Agreements and Network Provider Agreements requiring Subcontractors, Downstream Subcontractors, and Network Providers to comply with this Exhibit E, Subsection 1.1.23 (*Confidentiality of Information*).

1.1.24 Pilot Projects

DHCS may establish pilot projects to test alternative managed care models tailored to suit the needs of populations with special health care needs. The operation of these pilot projects may result in the disenrollment of Members that participate. Implementation of a pilot project may affect Contractor's obligations under this Contract. Any changes in the obligations of Contractor that are necessary for the operation of a pilot project in Contractor's Service Area will be implemented through a contract amendment.

1.1.25 Cost Avoidance and Post-Payment Recovery of Other Health Coverage

A. Contractor must Cost Avoid or make a Post-Payment Recovery **(**PPR) for the reasonable value of services paid by Contractor and rendered to a Member whenever a Member's Other Health Coverage (OHC) covers the same services, fully or partially. However, in no event may Contractor Cost Avoid or seek PPR for the reasonable value of services from a Third-Party Tort Liability (TPTL) action or make a claim against the estates of deceased Members.

B. Contractor must, at a minimum, utilize the Medi-Cal eligibility record for Cost Avoidance and PPR purposes.

C. Contractor retains all monies for PPR when Contractor initiates and completes recovery within 12 months from the date of payment of a service. Any monies for PPR obtained after the 12 months following the date of payment of a service are considered Medi-Cal recoveries and must be remitted to DHCS.

D. If Contractor initiates an active repayment plan with Network Providers or third-party insurance carriers that is agreed upon prior to, and extends beyond 12 months from, the date of payment of a service, Contractor will be allowed to retain the recovered monies.

E. Contractor must coordinate benefits with other coverage programs and entitlements, recognizing the OHC as primary and the Medi-Cal program

as the payer of last resort, except for services in which Medi-Cal is required to be the primary payer.

F. If Contractor does not perform PPR for a Member with OHC, Contractor must demonstrate to DHCS, upon request, that the cost of PPR exceeds the total Contract Revenues Contractor projects it would receive from such activity.

G. Cost Avoidance

1) Contractor must not pay claims for services provided to a Member whose Medi-Cal eligibility record indicates third-party coverage, designated by an OHC code or Medicare coverage, without proof that the Provider has first exhausted all sources of other payments. Acceptable forms of proof that all sources of payment have been exhausted or do not apply include a denial letter from the OHC for the service, an explanation of benefits indicating that the service is not covered by the OHC, or documentation demonstrating that Provider has billed the OHC and received no response for at least 90 calendar days.

2) Contractor must ensure that Providers do not refuse to provide Covered Services to Members, when OHC is indicated on a Member's Medi-Cal eligibility record.

3) Contractor must allow Providers to direct bill services that meet DHCS' requirements for direct billing without attempting to Cost Avoid those services. Cost Avoidance is not required prior to payment for services provided to Members with OHC codes A or N. More information on services that qualify for direct billing can be found in the Medi-Cal Provider Manual, Part 2 – General Medicine, section "Other Health Coverage (OHC): CPT-4 and HCPCS Codes (oth hlth cpt)".

4) Prior to delivering services, Contractor must ensure that Providers review the Member's Medi-Cal eligibility record for third-party coverage, designated by OHC or Medicare coverage code. If the Member's Medi-Cal eligibility record indicates OHC and the requested service is covered by OHC, Contractor must ensure that Providers notify the Member to seek the service from OHC.

5) When Contractor denies a claim due to OHC, Contractor must include OHC information in its notice of claim denial to Provider. OHC information includes, but is not limited to, the name of the OHC or Medicare carrier, and contact or billing information of the OHC.

H. Reporting Requirements for Cost Avoidance

Contractor must report new OHC information not found on the Medi-Cal eligibility record or that is different from what is reflected on the Medi-Cal eligibility record to DHCS within ten calendar days of discovery. Contractor must report discrepancies in the Medi-Cal record by either completing and submitting an OHC removal or addition form found online at https://www.dhcs.ca.gov or reporting OHC information to DHCS in batch updates. Batch updates regarding OHC information are processed by DHCS on a weekly basis. Contractor may contact its DHCS Contract Manager for more information regarding this process.

I. Post-Payment Recovery

1) Contractor must pay Provider's claim and then seek to recover the cost of the claim by billing the liable third parties in either of the following circumstances:

   a) The Member had OHC code A on their Medi-Cal eligibility record at the time of service; or

   b) For services defined by DHCS as preventive pediatric services.

2) When Contractor discovers that a service was provided to a Member with OHC designated in the Medi-Cal eligibility record, and Contractor did not properly Cost Avoid the service, then Contractor must bill the OHC for the cost of actual services rendered. If OHC is discovered retroactively, Contractor must also bill the OHC for the cost of actual services rendered.

3) Contractor must bill the liable OHC for the cost of services provided to Members. Billing and recoupment must be completed within 12 months from the date of payment of a service.

4) Monies recovered by DHCS or DHCS' contracted recovery agent starting on the first day of the 13th month after the date of payment of a service will be retained by DHCS.

J. Reporting Requirements

Contractor must submit a monthly PPR Report to DHCS via Secure File Transfer Protocol (SFTP) by the 15th day of each month in a format specified by DHCS in APLs. This report must contain claims and recovery information and any other information specified by DHCS in APLs.

K. Contractor must have written policies and procedures implementing all of the requirements of this Subsection 1.1.25 (*Cost Avoidance and Post-Payment Recovery of Other Health Coverage*).

1.1.26 Third-Party Tort and Workers' Compensation Liability

Contractor must not make a claim for recovery of the value of Covered Services rendered to a Member in cases or instances involving casualty insurance, tort, Workers' Compensation, or class action claims. Contractor's failure to comply with this provision is non-delegable. In the event that Contractor's failure to comply with this provision negatively impacts DHCS' ability to recover its full statutory lien, DHCS reserves the right to deduct any losses from Contractor's Capitation Payments. To assist DHCS in exercising DHCS' exclusive responsibility for recovering casualty insurance, tort, Workers' Compensation, or class action claims, Contractor must meet the following requirements:

A. Within 30 calendar days of DHCS' request, submit all requested service and utilization information and, when requested, copies of paid invoices/claims for its Members, including information from Network Providers, out-of-Network Providers, Subcontractors, and Downstream Subcontractors. Service and utilization information and copies of paid invoices/claims must set out any services provided by Contractor, including, but not limited to, physical, mental, and dental health services. Records must include services provided on a Fee-For-Service, capitated basis, and any other payment arrangements, regardless of whether a payment was made or denied. The reasonable value of the services must be calculated as the usual, customary, and reasonable charge made to the general public for similar services, or the amount paid to Network Providers or out-of-Network Providers for similar services. No additional payment will be made to Contractor for compliance with this provision.

B. Submit the requested service and utilization information and paid invoices/claims in a form and manner specified by DHCS through DHCS designated SFTP, in compliance with the electronic format and process, as set forth in APLs . Contractor must include the attestation in a form and manner specified by DHCS signed by the custodian of records or a designee with knowledge of the Member Information provided to DHCS, as set forth in APLs.

C. Notify DHCS using the appropriate online notification form at the Third Party Liability and Recovery Division Online Forms page, https://dhcs.ca.gov/PIForms, within ten calendar days of receiving a request from attorneys, insurers, or Members for a lien, pursuant to DHCS' recovery rights. These requirements do not relieve Contractor of other legal duties to Contractor's Members or other entities, including,

without limitation, the duty to respond to Members' requests for their own Protected Health Information pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

D. Use the TPLManagedCare@dhcs.ca.gov inbox for all communications regarding Contractor's service and utilization information and copies of paid invoices/claims file submissions, to submit questions or comments related to the preparation and submission of these reports, and for issues related to accessing the SFTP folders.

E. Have written policies and procedures implementing all of the requirements of this Exhibit E, Subsection 1.1.26 (*Third-Party Tort and Workers' Compensation Liability*).

1.1.27 Litigation Support

A. Records

Upon request by DHCS, Contractor must timely gather, preserve, and provide, in the form and manner specified by DHCS, any information, subject to any lawful privileges, in the possession of Contractor or its Subcontractors, Downstream Subcontractors, or Network Providers , relating to threatened or pending litigation by or against DHCS. If Contractor asserts that any requested documents are covered by a lawful privilege, Contractor must:

1) Sufficiently identify the claimed privileged documents to reasonably identify the documents; and

2). State the privilege being claimed that supports withholding production of the document.

Contractor agrees to promptly provide DHCS with a copy of any documents provided to any party in any litigation by or against DHCS. Contractor acknowledges that time is of the essence in responding to such a request. Contractor will use its best efforts to immediately notify DHCS of any subpoenas, document production requests, or requests for records received by Contractor or its Subcontractors, Downstream Subcontractors, or Network Providers related to this Contract or the Subcontractor Agreements, Downstream Subcontractor Agreements, and Network Provider Agreements entered into under this Contract.

B. Document Authentication and Testimony

Contractor will make its personnel and employees available to DHCS to authenticate documents, provide testimony as a witness, act as a "person

most knowledgeable," and assist in other ways as requested by DHCS, in connection with litigation, Public Record Acts requests, subpoenas, inquiries, and/or audits by federal and State agencies and departments, and inquiries by third-parties, as requested by DHCS. No additional payments will be paid to Contractor for the activities described in this Exhibit E, Subsection 1.1.27 (*Litigation Support*).

1.1.28 Equal Opportunity Employer

Contractor must comply with all applicable federal and State employment discrimination laws. Contractor, must:

A. In all solicitations or advertisements for employees placed by or on behalf of Contractor, state that it is an equal opportunity employer;

B. Send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding, a DHCS-approved notice, advising the labor union or workers' representative of its commitment as an equal opportunity employer and post copies of the notice in conspicuous places available to employees and applicants for employment;

C. Not unlawfully discriminate against any employee or applicant for employment because of race, religious creed, color, national origin, ancestry, physical disability, mental disability, medical condition, genetic information, marital status, sex, gender, gender identity, gender expression, age, sexual orientation, or military and veteran status;

D. Ensure that the evaluation and treatment of its employees and applicants for employment are free of such discrimination and comply with the provisions of the Fair Employment and Housing Act (GC §12900 *et seq*.), and the applicable regulations promulgated thereunder (2 CCR § 11000 *et seq.*). The applicable regulations of the Fair Employment and Housing Council implementing GC section 12990, set forth in Subchapter 5 of Division 4.1 of Title 2 of the California Code of Regulations are incorporated into this Contract by reference and made a part hereof as if set forth in full;

E. Give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement; and

F. Include the nondiscrimination and compliance provisions of this clause in all contracts to perform work under the Contract, in accordance with 2 CCR section 11105.

1.1.29 Federal and State Nondiscrimination Requirements

Contractor must:

A. Comply with federal nondiscrimination requirements in Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972; the Age Discrimination Act of 1975; Sections 504 and 508 of the Rehabilitation Act of 1973, as amended; Titles II and III of the Americans with Disabilities Act of 1990, as amended; Section 1557 of the Patient Protection and Affordable Care Act of 2010; and federal implementing regulations promulgated under the above-listed statutes; and

B. Comply with California nondiscrimination requirements, including, without limitation, the Unruh Civil Rights Act, GC sections 7405 and 11135, W&I section 14029.91, and State implementing regulations.

1.1.30 Discrimination Prohibitions

A. Member Discrimination Prohibition

Contractor must not unlawfully discriminate against Members or Potential Members on the basis of any characteristic protected under federal or State nondiscrimination law, including sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code section 422.56, in accordance with the statutes identified in Exhibit E, Subsection 1.1.29 (*Federal and State Nondiscrimination Requirements*) above, rules and regulations promulgated pursuant thereto, or as otherwise provided by law. For the purpose of this Contract, discrimination includes, but is not limited to, unlawfully:

1) Denying any Member Covered Services or availability of a Facility;

2) Providing a Member with any Covered Service that is different, or is provided in a different manner or at a different time from that which is provided to other Members under this Contract except where medically indicated;

3) Subjecting a Member to segregation, separate treatment, or harassment in any manner related to the receipt of any Covered Service;

4) Restricting or harassing a Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any

Covered Service; treating a Member or Potential Member differently from others in determining whether they satisfy any admission, Enrollment, quota, eligibility, membership; or adding other requirements or conditions which Members must meet in order to be provided any Covered Service;

5) Assigning times or places for the provision of services on the basis of the sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code section 422.56, to the Members to be served;

6) Utilizing criteria or methods of administration which have the effect of subjecting individuals to discrimination;

7) Failing to make Auxiliary Aids available, or to make reasonable accommodations in policies, practices, or procedures, when necessary to avoid discrimination on the basis of disability; and

8) Failing to ensure meaningful access to programs and activities for Limited English Proficient (LEP) Members and Potential Members.

B. Member Affirmative Action

Contractor must take affirmative action to ensure that Members are provided Covered Services without regard to sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code section 422.56, except as needed to provide equal access to LEP Members or Members with disabilities, or where medically indicated. For the purposes of this Section, genetic information includes the carrying of a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genes will include, but are not limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

C. Discrimination Related To Health Status

Contractor must not discriminate against Members or Potential Members on the basis of their health status or requirements for health care services during Enrollment, re-Enrollment or disenrollment. Contractor must not

terminate the Enrollment of a Member based on an adverse change in the Member's health.

1.1.31 Small Business Participation and Disabled Veteran Business Enterprises Reporting Requirements

A. Contractor must comply with applicable requirements of California law relating to Disabled Veteran Business Enterprises (DVBE) commencing at Public Contract (PC) Code section 10230.

B. If for this Contract, Contractor made a commitment to achieve small business participation, then Contractor must annually and within 60 calendar days of receiving final payment under this Contract report to DHCS the actual percentage of small business participation that was achieved (GC § 14841).

C. If for this Contract, Contractor made a commitment to achieve DVBE participation, then Contractor must annually and within 60 calendar days of receiving final payment under this Contract certify in a report to DHCS:

1) The total amount Contractor received under the Contract;

2) The name and address of the DVBE(s) that participated in the performance of the Contract;

3) The amount each DVBE received from Contractor;

4) That all payments under the Contract have been made to the DVBE; and

5) The actual percentage of DVBE participation that was achieved. (Military and Veterans Code § 999.5(d); GC § 14841

1.1.32 Conflict of Interest Avoidance Requirements

Contractor will comply with all requirements relating to Contractor's obligations to avoid conflicts of interest as described in Exhibit H (*Conflict of Interest Avoidance Requirements*).

1.1.33 Guaranty Provision

If Contractor is a subsidiary of another entity, Contractor must submit a guaranty from any entity in Contractor's chain of ownership that is publicly traded. If no such parent entity is publicly traded, the guaranty must be submitted by a parent entity at a level in the chain of ownership that is acceptable to DHCS. The guaranty must meet all requirements set forth in

Exhibit I (*Contractor's Parent Guaranty Requirements*) of this Contract and be in a form satisfactory to DHCS, and provide for the full and prompt performance of all covenants, terms and conditions, and agreements throughout the term of the Contract.

1.1.34 Priority of Provisions

In the event of a conflict between the provisions of Exhibit D(f) (*Special Terms and Conditions*) and any other Exhibits of this Contract, the provisions in the other Exhibits will prevail over the provisions in Exhibit D(f). Additionally, where Exhibit D(f) contains provisions on the same subject matter as a provision in another Exhibit of this Contract, the language in the other Exhibit preempt and prevail over the language in Exhibit D(f).

In the event of a conflict between any Article summary (Articles 2.0, 3.0, 4.0, 5.0, 6.0, and 7.0) and a more specific term in this Contract, the more specific term will prevail over the Article summary.

1.1.35 Additional Incorporated Provisions – Proposals

Any and all final Proposals, including Exhibits and Attachments (collectively referred to as "Proposal"), submitted by Contractor in response to the Request for Proposal 20-10029 (RFP), or any subsequent Requests for Proposal in connection with any managed care contract, are hereby incorporated by reference into this Contract. DHCS is relying on Contractor's representations in Contractor's Proposal in awarding contracts, and, accordingly, DHCS may enforce such representations against Contractor, including, but not limited to, representations that it will perform in a certain manner, provide enhanced services, and/or meet more stringent requirements than those required in the Contract. Contractor is required to obtain written approval from DHCS before implementing any such enhanced services or requirements reflected in Contractor's Proposal. In the event the Proposal(s) does not address Contract requirements, the Contract will govern.

1.1.36 Miscellaneous Provisions

A. Antitrust Claims

By signing this Contract, Contractor hereby certifies that if these services or goods are obtained by means of a competitive bid, Contractor must comply with the Antitrust Claims requirements of the GC sections 4550 *et seq.*.

B. Child Support Compliance Act

Contractor recognizes the importance of Child and family support obligations and must fully comply with all applicable State and federal laws relating to Child and family support enforcement (Chapter 8 (commencing with section 5200) of Part 5 of Division 9 of the Family Code).

C. Priority Hiring Considerations

Contractor must give priority consideration in filling vacancies in positions funded by the Contract to qualified recipients of aid under W&I section 11200 in accordance with PC section 10353.

D. Interoperability

1) Contractor must comply with the CMS Interoperability and Patient Access Final Rule, as set forth in 42 CFR sections 406, 407, 422, 423, 431, 438, 457, 482 and 485, and 45 CFR section 156.

2) Contractor must ensure that its contracted hospitals comply with the electronic notification requirements as set forth in 42 CFR section 482.24(d).

3) Contractor must participate in the California Health and Human Services Data Exchange Framework to exchange health information or provide access to health information to and from various entities in real time as set forth in H&S section 130290.

E. Electronic Visit Verification

All Network Providers who are eligible must comply with Electronic Visit Verification (EVV) requirements.

1) Contractor must collaborate with DHCS, and take action as required by DHCS, to comply with and ensure that its Subcontractors, Downstream Subcontractors, and Network Providers comply with federal requirements for Electronic Visit Verification (EVV) set forth in 42 USC section 1396b(l) and with State requirements for EVV set forth in W&I section 14043.51, Section 12006(a) of the Federal Cures Act, and APL 22-014.

2) Contractor must implement and ensure that its applicable Subcontractors, Downstream Subcontractors, and Network Providers implement a State-approved EVV solution, as required, for personal care services and home health care services provided in a Member’s home.

3) Contractor must verify that all Network Providers capture and transmit the following six mandatory data components when providing Personal Care Services and Home Health Care Services in a Member's home:

a) The type of service performed;

b) The individual receiving the service;

c) The date of the service;

d) The location of service delivery;

e) The individual providing the service; and

f) The time the service begins and ends.

4) Contractor must monitor and ensure all Network Providers comply with the EVV requirements when rendering personal care services and home health care services, subject to federal EVV requirements in accordance with APL 22-014 and the established guidelines below:

a) Monitor providers for compliance with the EVV requirements and Information Notice(s), and alert DHCS to any compliance issues.

b) Supply Providers with technical assistance and training on EVV compliance.

c) Require Providers to comply with an approved corrective action plan.

d) Deny payment if the Provider is not complying with EVV requirements and arrange for Members to receive services from a Provider who does comply.

1.1.37 Data Sharing

A. General Statement

Contractor must transfer all data in compliance with the terms of this Contract, including but not limited to the requirements of Exhibit G (*Business Associate Addendum*). Nothing in this Contract is exhaustive, exclusive, or limiting of DHCS' ability to provide data to Contractor or receive data from Contractor should DHCS determine, in its sole

discretion, that the data is necessary and appropriate for Contractor to perform its duties under this Contract.

B. Post-Termination/Expiration Transactions; Survival of Terms

When this Contract terminates or expires, Contractor must continue to exchange data in order to facilitate an orderly phaseout of Contract requirements including, but not limited to, data sharing in connection with continuity of care for Members, Encounter Data reconciliation, Network Provider Data Reporting, and payment reconciliation. These phaseout transactions will require the transfer of data between Contractor and DHCS, including Protected Health Information (PHI) and other potentially sensitive data. To facilitate the safe and secure transfer of data, all requirements of this Contract pertaining to the transfer of data, including but not limited to Exhibit G (*Business Associate Addendum)*, will survive the termination or expiration of this Contract for as long as any PHI or other sensitive data remains in the possession of Contractor. This Subsection is intended to supplement and not replace the requirements of Exhibit G (*Business Associate Addendum*) regarding data sharing.

Exhibit F – Contractor's Release

Contractor's Release

Instructions to Contractor:

With final invoice(s), submit one (1) original and one (1) copy. The original must bear the original signature of a person authorized to bind Contractor. The additional copy may bear photocopied signatures.

Submission of Final Invoice

Pursuant to **contract number** _____entered into between the Department of Health Care Services (DHCS) and Contractor (identified below), Contractor does acknowledge that final payment has been requested via **invoice number(s)** _____, in the **amount(s) of $** _____and **dated** _____. If necessary, enter "See Attached" in the appropriate blocks and attach a list of invoice numbers, dollar amounts and invoice dates.

Release of all Obligations

By signing this form, and upon receipt of the amount specified in the invoice number(s) referenced above, Contractor does hereby release and discharge the State, its officers, agents and employees of and from any and all liabilities, obligations, claims, and demands whatsoever arising from the above referenced contract.

Repayments Due to Audit Exceptions / Record Retention

By signing this form, Contractor acknowledges that expenses authorized for reimbursement do not guarantee final allowability of said expenses. Contractor agrees that the amount of any sustained audit exceptions resulting from any subsequent audit made after final payment will be refunded to the State.

All expense and accounting records related to the above referenced contract must be maintained for audit purposes for no less than three years beyond the date of final payment, unless a longer term is stated in said contract.

Recycled Product Use Certification

By signing this form, Contractor certifies under penalty of perjury that a minimum of 0% unless otherwise specified in writing of postconsumer material, as defined in the Public Contract Code Section 12200, in products, materials, goods, or supplies offered or sold to the State regardless of whether it meets the requirements of Public Contract Code Section 12209. Contractor specifies that printer or duplication cartridges offered or sold to the State comply with the requirements of Public Contract Code Section 12156(e).

Reminder to Return State Equipment/Property (If Applicable)

(Applies only if equipment was provided by DHCS or purchased with or reimbursed by contract funds)

Unless DHCS has approved the continued use and possession of State equipment (as defined in the above referenced contract) for use in connection with another DHCS agreement, Contractor agrees to promptly initiate arrangements to account for and return said equipment to DHCS, at DHCS' expense, if said equipment has not passed its useful life expectancy as defined in the above referenced contract.

Patents / Other Issues

By signing this form, Contractor further agrees, in connection with patent matters and with any claims that are not specifically released as set forth above, that it will comply with all of the provisions contained in the above referenced contract, including, but not limited to, those provisions relating to notification to the State and related to the defense or prosecution of litigation.

ONLY SIGN AND DATE THIS DOCUMENT WHEN ATTACHING IT TO THE FINAL INVOICE

Contractor’s Legal Name (as on contract):
Signature of Contractor or Official Designee:
Date:

Printed Name/Title of Person Signing:
Distribution: Accounting (Original) Program

Exhibit G – Business Associate Addendum

1. This Agreement has been determined to constitute a business associate relationship under the Health Insurance Portability and Accountability Act (HIPAA) and its implementing privacy and security regulations at 45 Code of Federal Regulations parts 160 and 164 (collectively, and as used in this Agreement)

2. The term "Agreement" as used in this document refers to and includes both this Business Associate Addendum and the contract to which this Business Associate Agreement is attached as an exhibit, if any.

3. For purposes of this Agreement, the term "Business Associate" shall have the same meaning as set forth in 45 CFR section 160.103.

4. The Department of Health Care Services (DHCS) intends that Business Associate may create, receive, maintain, transmit or aggregate certain information pursuant to the terms of this Agreement, some of which information may constitute Protected Health Information (PHI) and/or confidential information protected by federal and/or State laws.

4.1 As used in this Agreement and unless otherwise stated, the term "PHI" refers to and includes both "PHI" as defined at 45 CFR section 160.103 and Personal Information (PI) as defined in the Information Practices Act (IPA) at California Civil Code section 1798.3(a). PHI includes information in any form, including paper, oral, and electronic.

4.2 As used in this Agreement, the term "confidential information" refers to information not otherwise defined as PHI in Section 4.1 of this Agreement, but to which State and/or federal privacy and/or security protections apply.

5. Contractor (however named elsewhere in this Agreement) is the Business Associate of DHCS acting on DHCS' behalf and provides services or arranges, performs or assists in the performance of functions or activities on behalf of DHCS, and may create, receive, maintain, transmit, aggregate, use or disclose PHI (collectively, "use or disclose PHI") in order to fulfill Business Associate's obligations under this Agreement. DHCS and Business Associate are each a party to this Agreement and are collectively referred to as the "parties."

6. The terms used in this Agreement, but not otherwise defined, shall have the same meanings as those terms in HIPAA and/or the IPA. Any reference to statutory or regulatory language shall be to such language as in effect or as amended.

7. Permitted Uses and Disclosures of PHI by Business Associate. Except as otherwise indicated in this Agreement, Business Associate may use or disclose PHI, inclusive of de-identified data derived from such PHI, only to perform functions, activities or services specified in this Agreement on behalf of DHCS, provided that

such use or disclosure would not violate HIPAA or other applicable laws if done by DHCS.

7.1 Specific Use and Disclosure Provisions. Except as otherwise indicated in this Agreement, Business Associate may use and disclose PHI if necessary for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate. Business Associate may disclose PHI for this purpose if the disclosure is required by law, or the Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person. The person notify the Business Associate of any instances of which the person is aware that the confidentiality of the information has been breached, unless such person is a treatment provider not acting as a business associate of Business Associate.

8. Compliance with Other Applicable Law

8.1 To the extent that other State and/or federal laws provide additional, stricter and/or more protective (collectively, more protective) privacy and/or security protections to PHI or other confidential information covered under this Agreement beyond those provided through HIPAA, Business Associate agrees:

8.1.1 To comply with the more protective of the privacy and security standards set forth in applicable State or federal laws to the extent such standards provide a greater degree of protection and security than HIPAA or are otherwise more favorable to the individuals whose information is concerned; and

8.1.2 To treat any violation of such additional and/or more protective standards as a breach or security incident, as appropriate, pursuant to Section 18. of this Agreement.

8.2 Examples of laws that provide additional and/or stricter privacy protections to certain types of PHI and/or confidential information, as defined in Section 4. of this Agreement, include, but are not limited to the Information Practices Act, California Civil Code sections 1798-1798.78, Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR part 2, W&I section 5328, and Health and Safety Code section 11845.5.

8.3 If Business Associate is a Qualified Service Organization (QSO) as defined in 42 CFR section 2.11, Business Associate agrees to be bound by and comply with subdivisions (2)(i) and (2)(ii) under the definition of QSO in 42 CFR section 2.11.

9. Additional Responsibilities of Business Associate

Nondisclosure. Business Associate not use or disclose PHI or other confidential information other than as permitted or required by this Agreement or as required by law.

9.1 Safeguards and Security.

9.1.1 Business Associate use safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI and other confidential data and comply, where applicable, with subpart C of 45 CFR part 164 with respect to electronic protected health information, to prevent use or disclosure of the information other than as provided for by this Agreement. Such safeguards **must** be based on applicable Federal Information Processing Standards (FIPS) Publication 199 protection levels.

9.1.2 Business Associate, at a minimum, utilize a National Institute of Standards and Technology Special Publication (NIST SP) 800-53 compliant security framework when selecting and implementing its security controls and maintain continuous compliance with NIST SP 800-53 as it may be updated from time to time. The current version of NIST SP 800-53, Revision 5 is available online; updates will be available online at the NIST Computer Security Resource Centerhttps://csrc.nist.gov/publications/sp800.

9.1.3 Business Associate employ FIPS 140-2 validated encryption of PHI at rest and in motion unless Business Associate determines it is not reasonable and appropriate to do so based upon a risk assessment, and equivalent alternative measures are in place and documented as such. FIPS 140-2 validation can be determined online at the NIST Cryptographic Module Validation Program page, with information about the Cryptographic Module Validation Program under FIPS 140-2 available online. In addition, Business Associate maintain, at a minimum, the most current industry standards for transmission and storage of PHI and other confidential information.

9.1.4 Business Associate apply security patches and upgrades, and keep virus software up-to-date, on all systems on which PHI and other confidential information may be used.

9.1.5 Business Associate ensure that all members of its workforce with access to PHI and/or other confidential information sign a confidentiality statement prior to access to such data. The statement be renewed annually.

9.1.6 Business Associate identify the security official who is responsible for the development and implementation of the policies and procedures required by 45 CFR part 164, subpart C.

9.2 Business Associate's Agent. Business Associate ensure that any agents, subcontractors, subawardees, vendors or others (collectively, "agents") that use or disclose PHI and/or confidential information on behalf of Business Associate agree to the same restrictions and conditions that apply to Business Associate with respect to such PHI and/or confidential information.

10. **Mitigation of Harmful Effects**. Business Associate mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI and other confidential information in violation of the requirements of this Agreement.

11. **Access to PHI.** Business Associate make PHI available in accordance with 45 CFR section 164.524.

12. **Amendment of PHI.** Business Associate make PHI available for amendment and incorporate any amendments to protected health information in accordance with 45 CFR section 164.526.

13. **Accounting for Disclosures.** Business Associate make available the information required to provide an accounting of disclosures in accordance with 45 CFR section 164.528.

14. **Compliance with DHCS Obligations.** To the extent Business Associate is to carry out an obligation of DHCS under 45 CFR part 164, subpart E, comply with the requirements of the subpart that apply to DHCS in the performance of such obligation.

15. **Access to Practices, Books and Records.** Business Associate make its internal practices, books, and records relating to the use and disclosure of PHI on behalf of DHCS available to DHCS upon reasonable request, and to the federal Secretary of Health and Human Services for purposes of determining DHCS' compliance with 45 CFR part 164, subpart E.

16. **Return or Destroy PHI on Termination; Survival.** At termination of this Agreement, if feasible, Business Associate return or destroy all PHI and other confidential information received from, or created or received by Business Associate on behalf of, DHCS that Business Associate still maintains in any form and retain no copies of such information. If return or destruction is not feasible, Business Associate notify DHCS of the conditions that make the return or destruction infeasible, and DHCS and Business Associate determine the terms and conditions under which Business Associate may retain the PHI. If such return or destruction is not feasible, Business Associate extend the protections of this Agreement to the information and limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

17. **Special Provision for SSA Data.** If Business Associate receives data from or on behalf of DHCS that was verified by or provided by the Social Security Administration (SSA data) and is subject to an agreement between DHCS and SSA, Business Associate provide, upon request by DHCS, a list of all employees and agents and

employees who have access to such data, including employees and agents of its agents, to DHCS.

18. **Breaches and Security Incidents.** Business Associate must implement reasonable systems for the discovery and prompt reporting of any breach or security incident, and take the following steps:

18.1 Notice to DHCS.

18.1.1 Business Associate **must** notify DHCS **immediately** upon the discovery of a suspected breach or security incident that involves SSA data. This notification will be provided by email upon discovery of the breach. If Business Associate is unable to provide notification by email, then Business Associate **must** provide notice by telephone to DHCS.

18.1.2 Business Associate **must** notify DHCS **within 24 hours by email** (or by telephone if Business Associate is unable to email DHCS) of the discovery of the following, unless attributable to a treatment provider that is not acting as a business associate of Business Associate:

18.1.2.1 Unsecured PHI if the PHI is reasonably believed to have been accessed or acquired by an unauthorized person;

18.1.2.2 Any suspected security incident which risks unauthorized access to PHI and/or other confidential information;

18.1.2.3 Any intrusion or unauthorized access, use or disclosure of PHI in violation of this Agreement; or

18.1.2.4 Potential loss of confidential information affecting this Agreement.

18.1.3 Notice be provided to the DHCS Program Contract Manager (as applicable), the DHCS Privacy Office, and the DHCS Information Security Office (collectively, "DHCS Contacts") using the DHCS Contact Information at Section 18.6. below.

Notice be made using the current DHCS "Privacy Incident Reporting Form" ("PIR Form"; the initial notice of a security incident or breach that is submitted is referred to as an "Initial PIR Form") and include all information known at the time the incident is reported. The Privacy Incident Reporting Form is available online.

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

18.1.3.1 Prompt action to mitigate any risks or damages involved with the security incident or breach; and

18.1.3.2 Any action pertaining to such unauthorized disclosure required by applicable federal and State law.

18.2 Investigation. Business Associate **must** immediately investigate such security incident or breach.

18.3 Complete Report. To provide a complete report of the investigation to the DHCS contacts within ten (10) working days of the discovery of the security incident or breach. This "Final PIR" include any applicable additional information not included in the Initial Form. The Final PIR Form include an assessment of all known factors relevant to a determination of whether a breach occurred under HIPAA and other applicable federal and State laws. The report also include a full, detailed corrective action plan, including its implementation date and information on mitigation measures taken to halt and/or contain the improper use or disclosure. If DHCS requests information in addition to that requested through the PIR form, Business Associate make reasonable efforts to provide DHCS with such information. A "Supplemental PIR" may be used to submit revised or additional information after the Final PIR is submitted. DHCS will review and approve or disapprove Business Associate's determination of whether a breach occurred, whether the security incident or breach is reportable to the appropriate entities, if individual notifications are required, and Business Associate's corrective action plan.

18.3.1 If Business Associate does not complete a Final PIR within the ten (10) working day timeframe, Business Associate **must** request approval from DHCS within the ten (10) working day timeframe of a new submission timeframe for the Final PIR.

18.4 Notification of Individuals. If the cause of a breach is attributable to Business Associate or its agents, other than when attributable to a treatment provider that is not acting as a business associate of Business Associate, Business Associate **must** notify individuals accordingly and pay all costs of such notifications, as well as all costs associated with the breach. The notifications comply with applicable federal and State law. DHCS approve the time, manner and content of any such notifications and their review and approval be obtained before the notifications are made.

18.5 Responsibility for Reporting of Breaches to Entities Other than DHCS. If the cause of a breach of PHI is attributable to Business Associate or its agents, other than when attributable to a treatment provider that is not acting as a business associate of Business Associate, Business Associate is responsible for all required reporting of the breach as required by applicable federal and State law.

18.6 DHCS Contact Information. To direct communications to the above referenced DHCS staff, the Contractor **must** initiate contact as indicated here. DHCS reserves the right to make changes to the contact information

below by giving written notice to Business Associate. These changes shall not require an amendment to this Agreement.

DHCS Program Contract Manager	DHCS Privacy Office	DHCS Information Security Office
See the Scope of Work exhibit for Program Contract Manager information. If this Business Associate Agreement is not attached as an exhibit to a contract, contact the DHCS signatory to this Agreement.	Privacy Office c/o: Office of HIPAA Compliance Department of Health Care Services P.O. Box 997413, MS 4722 Sacramento, CA 95899-7413 Email: incidents@dhcs.ca.gov Telephone: (916) 445-4646	Information Security Office DHCS Information Security Office P.O. Box 997413, MS 6400 Sacramento, CA 95899-7413 Email: incidents@dhcs.ca.gov

19. **Responsibility of DHCS.** DHCS agrees to not request the Business Associate to use or disclose PHI in any manner that would not be permissible under HIPAA and/or other applicable federal and/or State law.

20. **Audits, Inspection and Enforcement**

20.1 From time to time, DHCS may inspect the facilities, systems, books and records of Business Associate to monitor compliance with this Agreement. Business Associate promptly remedy any violation of this Agreement and certify the same to the DHCS Privacy Officer in writing. Whether or how DHCS exercises this provision shall not in any respect relieve Business Associate of its responsibility to comply with this Agreement.

20.2 If Business Associate is the subject of an audit, compliance review, investigation or any proceeding that is related to the performance of its obligations pursuant to this Agreement, or is the subject of any judicial or administrative proceeding alleging a violation of HIPAA, Business Associate promptly notify DHCS unless it is legally prohibited from doing so.

21. **Termination**

21.1 Termination for Cause. Upon DHCS' knowledge of a violation of this Agreement by Business Associate, DHCS may in its discretion:

21.1.1 Provide an opportunity for Business Associate to cure the violation and terminate this Agreement if Business Associate does not do so within the time specified by DHCS; or

21.1.2 Terminate this Agreement if Business Associate has violated a material term of this Agreement.

21.2 Judicial or Administrative Proceedings. DHCS may terminate this Agreement if Business Associate is found to have violated HIPAA, or stipulates or consents to any such conclusion, in any judicial or administrative proceeding.

22. Miscellaneous Provisions

22.1 Disclaimer. DHCS makes no warranty or representation that compliance by Business Associate with this Agreement will satisfy Business Associate's business needs or compliance obligations. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI and other confidential information.

22.2. Amendment.

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

22.2.2 Failure by Business Associate to take necessary actions required by amendments to this Agreement under Section 22.2.1 shall constitute a material violation of this Agreement.

22.3 Assistance in Litigation or Administrative Proceedings. Business Associate make itself and its employees and agents available to DHCS at no cost to DHCS to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against DHCS, its directors, officers and/or employees based upon claimed violation of HIPAA, which involve inactions or actions by the Business Associate.

22.4 No Third-Party Beneficiaries. Nothing in this Agreement is intended to or shall confer, upon any third person any rights or remedies whatsoever.

22.5 Interpretation. The terms and conditions in this Agreement shall be interpreted as broadly as necessary to implement and comply with HIPAA and other applicable laws.

22.6 No Waiver of Obligations. No change, waiver or discharge of any liability or obligation hereunder on any one or more occasions shall be deemed a waiver

of performance of any continuing or other obligation, or shall prohibit enforcement of any obligation, on any other occasion.

Exhibit H – Conflict of Interest Avoidance Requirements

1.0 The Department of Health Care Services (DHCS) requires Contractor to avoid conflicts of interest or the appearance of conflicts of interest. DHCS reserves the right to determine, in DHCS' sole discretion, whether any information received from any source indicates the existence of a potential, suspected, and/or actual conflict of interest.

Exhibit H

1.0 Conflict of Interest Avoidance Requirements

1.1.1 Introduction
1.1.2 Identification of Ownership, Contractual, and Financial Interests
1.1.3 Conflicts of Interest
1.1.4 DHCS Approval of Conflict Avoidance Plan
1.1.5 Third-Party Monitor Oversight
1.1.6 DHCS' Right of Termination
1.1.7 Notice of Conflict of Interest to DHCS

1.0 Conflict of Interest Avoidance Requirements

1.1.1 Introduction

Contractor must ensure that it complies with the conflict of interest avoidance requirements set forth in this Exhibit H and must also ensure the compliance of its employees, officers, and directors throughout the entire term of the Contract, and any extensions thereto. Contractor must also ensure that its Subcontractors and Downstream Subcontractors (as those terms are defined in the Contract), and the employees, officers and directors of Subcontractors and Downstream Subcontractors, comply with the requirements set forth in this Exhibit H throughout the entire term of the Contract, and any extension thereto.

1.1.2 Identification of Ownership, Contractual, and Financial Interests

Contractor will disclose the following to DHCS, in a form and manner directed by DHCS through All Plan Letter (APL) or other similar instructions:

A. Any form of ownership interest, affiliation, financial interest, contractual relationship, and/or control Contractor has in any corporation or other entity that operates as a Medi-Cal managed care health plan, Prepaid Inpatient Health Plan (PIHP), Prepaid Ambulatory Health Plan (PAHP), Primary Care Case Management (PCCM), pharmaceutical company or any other health care provider, fiscal intermediary, billing agent, or any other controlling agent for Medi-Cal services (“Medi-Cal Program Participant”); and

B. Any form of ownership interest, affiliation, financial interest, contractual relationship, and/or control Contractor has in any corporation, partnership, limited partnership, limited liability company, sole proprietorship, or any other legal entity that is not a Medi-Cal Program Participant.

To the extent any interest identified by Contractor in Section 1.2 results in a potential, suspected, and/or actual conflict of interest, Contractor will be subject to all requirements of this Exhibit H.

1.1.3 Conflicts of Interest

If Contractor has a potential, suspected, and/or actual conflict of interest, Contractor must provide a description of the relationship and a conflict avoidance plan to ensure that such a relationship will not adversely affect DHCS, other Medi-Cal managed care plans, and/or Medi-Cal Members. In the conflict avoidance plan, Contractor must also establish procedures to avoid, neutralize, and/or mitigate a potential, suspected, and/or actual conflict of interest.

Any of the following instances would be considered a potential, suspected, and/or actual conflict of interest, including but not limited to any of these instances in the past, present, or future:

A. An instance where Contractor or any of its Subcontractors and Downstream Subcontractors, or any employee, officer, or director of Contractor or any of its Subcontractors and Downstream Subcontractors, has an interest, financial or otherwise, whereby the use or disclosure of information obtained while performing services under the Contract would allow for private or personal benefit or for any purpose that is inconsistent with the goals and objectives of the Contract;

B. An instance where Contractor or any of its Subcontractors and Downstream Subcontractors, or any employee, officer, or director of Contractor or any of its Subcontractors and Downstream Subcontractors, improperly uses their positions for purposes that are, or give the appearance of being, for private gain for themselves or others, such as those with whom they have family, business, or other ties that are determined by DHCS to be a conflict of interest;

C. An instance where Contractor or any of its Subcontractors and Downstream Subcontractors, or any employee, officer, or director of Contractor or any of its Subcontractors and Downstream Subcontractors, gains an unfair competitive advantage due to its unequal access to information, such as where non-public information gained on one contract by Contractor may be leveraged in bidding for another government contract;

   1) Where pursuant to the Political Reform Act (Govt. Code (GC) §§ 87100–87500), a DHCS official has an economic Interest in Contractor and the official makes, participates in the making of, or uses his or her official position to influence the making of a decision involving Contractor where it is reasonably foreseeable that the decision could materially affect the official's economic interest;

   2) Where pursuant to GC section 1090 *et seq*., a DHCS official participates in the making of a Contract with Contractor and the official is financially interested in the Contract;

   3) Where in contravention of Welfare and Institutions Code (W&I) section 14479, a DHCS officer or employee is employed in a management or consultant position by Contractor, Subcontractor, or Downstream Subcontractor one year after the DHCS officer or employee terminates their State employment; and

4) For Two-Plan managed care models, an instance where Contractor will be contracted, affiliated, or otherwise entered into a partnership arrangement to serve as a Local Initiative in the same Two-Plan county where Contractor is operating as the commercial plan, or has indicated an intent to do so.

D. Conflict Avoidance Plan Framework

The requirements of a conflict avoidance plan will vary depending on the nature of the conflict, but must include, at a minimum, the following elements:

1) Clear definitions;

2) Statement of organizational commitment to develop and follow the conflict avoidance plan;

3) Description of the type of conflict of interest (*e.g.*, unequal access to information, impaired objectivity, and/or biased ground rules implicated by a contract);

4) Description of the factors that may or do place Contractor in a potential, suspected, and/or actual conflict of interest situation;

5) If applicable, identification of Subcontractors and Downstream Subcontractors with potential, suspected, and/or actual conflict of interest;

6) Detailed plans for avoiding, neutralizing, and/or mitigating conflicts of interest, or, if not feasible, an explanation and justification for accepting conflicts of interest;

7) Administrative, technical, physical, and management controls, as required in the context of the specific conflict of interest;

8) Provision for third-party monitoring and a requirement that the third-party monitor certify Contractor's compliance with the conflict avoidance plan, if required by DHCS;

9) Contractor's certification of compliance with the conflict avoidance plan; and

10) Provisions requiring periodic review and amendment by Contractor of the conflict avoidance plan to address material changes impacting the conflict of interest.

1.1.4 DHCS Approval of Conflict Avoidance Plan

DHCS, in its sole discretion, will determine whether the specific provisions of the conflict avoidance plan satisfactorily address the actual, suspected, or potential conflicts of interest. DHCS, in its sole discretion, may impose additional requirements or require modification to the conflict avoidance plan, which may include, but are not limited to, the following:

A. Termination of contractual obligations that in DHCS' determination create actual or potential conflicts of interest;

B. Removal of Contractor's management or staff who DHCS determines were involved in the relationship creating the conflict of interest; and/or

C. Creation of an "ethical firewall," with measures to ensure that no information passes between individuals/entities within Contractor's organization that were involved in the conflict and those individuals/entities not involved in the conflict.

These requirements will vary, depending on the nature of the potential, suspected, and/or actual conflicts of interest, the manner in which those potential, suspected, and/or actual conflicts of interest impact the Contract, and DHCS' determination of the best method for addressing those conflicts of interest.

1.1.5 Third-Party Monitor Oversight

DHCS may, in its sole discretion, appoint a third-party monitor to assist in overseeing Contractor's compliance with the conflict avoidance plan. The third-party monitor's responsibilities will include monitoring, reporting, consulting, and, where necessary, investigation of compliance concerns. Appropriate provisions regarding the third-party monitor's duties and Contractor's obligations in connection with the third-party monitor will be included in the conflict avoidance plan.

1.1.6 DHCS' Right of Termination

If DHCS is aware or becomes aware of a potential, suspected, and/or actual conflict of interest, Contractor will be given an opportunity to submit additional information to resolve the conflict of interest. If Contractor has a potential, suspected, and/or actual conflict of interest, Contractor will have five Working Days from the date of notification by DHCS of the potential, suspected, and/or actual conflict of interest to provide complete information regarding the conflict of interest. If DHCS determines that an actual conflict of interest exists and the conflict cannot be resolved or mitigated to the satisfaction of DHCS, the conflict of interest will be grounds for termination of the Contract by DHCS for cause.

1.1.7 Notice of Conflict of Interest to DHCS

Contractor, and each of its Subcontractors and Downstream Subcontractors, must notify their DHCS Contract Manager within ten Working Days of when they become aware of any potential, suspected, or actual conflict of interest, or when any change occurs to the information provided to DHCS previously, whether provided previously through the Request for Procurement or previous notice given during the term of the Contract. This notice will be in a form and manner as directed by DHCS through APL or other similar instructions.

Exhibit I – Contractor's Parent Guaranty Requirements

1.0 Contractor's Parent Guaranty Requirements

If Contractor is a subsidiary of a corporation or other legal entity, the full and prompt performance of all covenants, provisions, and agreements resulting from this Contract for the life of the Contract must be guaranteed by that entity in Contractor's chain of ownership, which is publicly traded (the "Guaranty"). This entity will be known as Contractor's "parent corporation" for purposes of the Contract (the "Guarantor").

1.1 Contractor's Parent Guaranty Requirements

1.1.1 Minimum Requirements
1.1.2 Provisions
1.1.3 Terms

1.0 Contractor's Parent Guaranty Requirements

1.1.1 Minimum Requirements

The Guaranty must, at a minimum, meet the following requirements. It must:

A. Be made to DHCS, in writing, by the Contract effective date;

B. Be signed by an official authorized to bind the Guarantor organization;

C. Accept unconditional responsibility for all performance and financial requirements and obligations of the Contract including, but not limited to, maintenance of Tangible Net Equity (TNE) and payment of liquidated damages;

D. Recite that "for good and valuable consideration, receipt of which is hereby acknowledged," Guarantor is making the Guaranty;

E. State that Guarantor stipulates that if the Contract is ultimately awarded to the subsidiary, that DHCS will so award in reliance upon the Guaranty;

F. State that the undersigned corporate officer warrants that they have personally reviewed all pertinent corporate documents, including but not limited to, articles of incorporation, bylaws, and agreements between the parent and subsidiary; and

G. State that the undersigned corporate officer warrants that nothing in these documents in any way limits the capacity of the parent to enter into this Guaranty

1.1.2 Provisions

The Guaranty must include the following provisions:

A. DHCS need not take any action against Contractor, any other guarantor, or any other person, firm or corporation, or resort to any security held by Contractor at any time before proceeding against Guarantor;

B. Guarantor hereby waives any and all notices and demands which may be required to be given by any other statute or rule of law and agrees that its liability hereunder will be in no way affected, diminished, or released by any extension of time, forbearance, or waiver, which may be granted to Contractor, its successor or assignee;

C. This Guaranty will extend to and include all future amendments, modifications, and extensions of the Contract and all future supplemental

and other agreements with respect to matters covered by the Contract that DHCS and Contractor may enter into, with or without notice to or knowledge of Guarantor, but Guarantor will have the benefit of any such extension, forbearance, waiver, amendment, modification, or supplemental or other agreement. It is the purpose and intent of the parties hereto that the obligations of Guarantor hereunder will be co-extensive with, but not in excess of, the obligations of Contractor, its successor or assignee, under the Contract; and

D. Guarantor agrees that the Guaranty will continue in full force and effect despite any change in the legal or corporate status of the subsidiary, including, but not limited to, its sale, reorganization, dissolution or bankruptcy.

1.1.3 Terms

The Guaranty must be presented in terms, which DHCS in its sole discretion, determines, as a whole, adequately establish Contractor’s financial responsibility.

Exhibit J: Delegation Reporting and Compliance Plan

This Exhibit contains instructions and templates for Contractor to make submissions to DHCS per the requirements set forth in Exhibit A, Attachment III, Subsection 3.1.3 *(Contractor's Duty to Disclose All Delegated Relationships and to Submit Delegation Reporting and Compliance Plan)*. As with all Exhibits to the Contract, Exhibit J is a part of this Contract and the reporting requirements in this Exhibit J and the use of the prescribed template are binding and enforceable contractual obligations under this Contract. Contractor must complete Exhibit J for each county in which they operate.

Template A: Delegation Function Matrix

Instructions: Complete *Table A1: Delegation Function Matrix – For Subcontractor* for all functions that are delegated through applicable Subcontractor Agreements. Contractor may not delegate contractual duties and obligations where delegation is legally or contractually prohibited. Use additional pages of Table A1 as needed – additional pages will not be counted in the total page count for the Delegation Justification and Plan.

Contractor Name:

Applicable County:

Compliance Officer:

Compliance Contact Information:

1. **Subcontractor Name:** Name of the Subcontractor with whom Contractor has a Subcontractor Agreement
2. **Type of Subcontractor:** Fully Delegated Subcontractor, Partially Delegated Subcontractor, Administrative Subcontractor
3. **Delegated Function(s):** The function(s) Contractor is delegating to Subcontractor. In the case of a Fully Delegated Subcontractor, this may be "all delegable functions."
4. **Address:** The address for location of the performance of Subcontractor's functions

5. **Contact Info:** Name and contact information for each of Subcontractor's key personnel who is responsible for ensuring compliance.

6. **Medi-Cal Managed Care Member:** Percentage of the total Medi-Cal Members assigned to the Subcontractor if applicable.

7. **Proportion of Capitated Rates At Risk:** Proportion of total capitated rates for which the Subcontractor is at risk, if applicable.

Table A1: Delegation Function Matrix—For Subcontractors

Sub-contractor Name	Type of Sub-contractor	Delegated Function(s)	Address	Contact Info	Percentage of Total Members	Proportion of Total Capitated Rate
(1)	**(2)**	**(3)**	**(4)**	**(5)**	**(6)**	**(7)**

Instructions: Complete *Table A2 Delegation Function Matrix—Downstream Subcontractors* for all functions that are delegated through applicable Downstream Subcontractor Agreements. Use additional pages of Table A2 as needed. Subcontractor or Downstream Subcontractor may not delegate contractual duties and obligations where delegation is legally or contractually prohibited. Complete one for each Subcontractor that delegates functions downstream and, as

applicable, for each Downstream Subcontractor, if they further delegate functions downstream. Use additional pages of Table A2 as needed – additional pages will not be counted in the total page count for the Delegation Justification and Plan.

Subcontractor or Downstream Subcontractors Name:
Applicable County(ies):
Compliance Officer:
Compliance Contact Information:

1. **Downstream Subcontractor Name:** Name of the Downstream Subcontractor with whom the Subcontractor has a Downstream Subcontractor Agreement; or the name of the Downstream Subcontractor with whom the Subcontractor's Downstream Subcontractor further delegates functions downstream
2. **Type of Downstream Subcontractor:** Downstream Fully Delegated Subcontractor, Downstream Partially Delegated Subcontractor, Downstream Administrative Subcontractor
3. **Delegated Function(s):** The function(s) Subcontractor is delegating to Downstream Subcontractor; in the case of a Downstream Fully Delegated Subcontractor, this may be "all delegable functions."
4. **Address:** The address of the location of the performance of the Downstream Subcontractor's functions.
5. **Contact Info:** Name and contact information for each of the Downstream Subcontractor's key personnel who is responsible for ensuring compliance.
6. **Medi-Cal Managed Care Member:** Percentage of the total Medi-Cal Members assigned to the Downstream Subcontractor, if applicable.
7. **Proportion of Capitated Rates At Risk:** Proportion of total capitated rates for which the Downstream Subcontractor, is at risk, if applicable.

Table A2: Delegation Function Matrix—For Downstream Subcontractors

Downstream Subcontractor Name	Type	Delegated Function(s)	Address	Contact Info	Percentage of Total Members	Proportion of Total Capitated Rate
(1)	**(2)**	**(3)**	**(4)**	**(5)**	**(6)**	**(7)**

Template B: Delegation Justification and Plan

Instructions: Complete this template for each Subcontractor or Downstream Subcontractor. Contractor may not delegate for those contractual duties and obligations where delegation is legally or contractually prohibited. Responses must be limited to no more than ten pages.

Subcontractor or Downstream Subcontractor Name:

Applicable County(ies):

Subcontractor or Downstream Key Personnel:

Subcontractor Key Personnel Contact Information:

Type of Subcontractor or Downstream Subcontractor: Fully delegated, Partially delegated, Administrative, Downstream Fully delegated, Downstream Partially delegated, Downstream Administrative:

a) **Justification of Subcontractor Agreement or Downstream Subcontractor Agreement:** Describe the purpose and the justification of the Subcontractor Agreement or Downstream Subcontractor Agreement.

b) **Pre-Existing Relationships:** Describe any pre-existing relationship, including any affiliation, parent entity, or prior existing contract between Contractor and Subcontractor, or Subcontractor and Downstream Subcontractor including the duration of such pre-existing relationship.

c) **Sub-Delegation**: Indicate if Subcontractor or Downstream Subcontractor is permitted to sub-delegate any functions. If so, describe how Contractor will maintain oversight over delegated functions to Subcontractors and Downstream Subcontractors. Provide citations to provisions in the Subcontractor Agreement and Downstream Subcontractor Agreement to support Contractor's assertions.

d) **Impact on Contractor:** Describe the impact and benefit, if any, the Subcontractor Agreement or Downstream Subcontractor Agreement will have on Contractor's operations, administrative capacity, and financial viability.

e) **Contractor's Administrative Capacity to Oversee and Monitor Subcontractor and Downstream Subcontractor:** Describe Contractor's administrative capacity to oversee and monitor Subcontractor and Downstream Subcontractor as applicable

f) **Subcontractor's and Downstream Subcontractor's Administrative Capacity:** Describe Subcontractor's and Downstream Subcontractor's administrative capacity to perform each delegated function, including but not limited to Subcontractor's and Downstream Subcontractor's capacity to perform quality monitoring and community engagement, if applicable.

g) **Subcontractor's and Downstream Subcontractors' Compliance with Applicable Contractual Provisions:** Detail how the Subcontractor Agreement and Downstream Subcontractor Agreement complies with, and ensures compliance, with all provisions of the Contract applicable to the delegated functions, including appropriate citations to the provisions in the Subcontractor Agreement and Downstream Subcontractor Agreement. Please complete Template C (Contract Requirements Grid) in Exhibit J to indicate which provisions are included in the Subcontractor Agreements and Downstream Subcontractor Agreements, as applicable for each Agreement.

h) **Contractor's Oversight Policy and Procedures:** Describe how Contractor will inform Subcontractor and Downstream Subcontractors of Contractor's oversight policies and procedures.

i) **Financial Arrangement:** Contractor must include description of any financial arrangements it has with Subcontractor and Downstream Subcontractor.

j) **Other Information:** Include any other information that would assist DHCS in its review of Contractor's delegated structure.

k) **Previously Approved Documents: (Applicable to annual submissions only)** If Contractor has previously submitted documentation to DHCS in connection with the Subcontractor Agreement or Downstream Subcontractor Agreement, either through the Request for Proposal (RFP) process or during the term of this Contract, Contractor must provide any such documentation.

Template C: Contract Requirements Grid

Instructions: If you delegate any functions, complete this template for those contractual duties. One Template C should be submitted showing all delegated functions to accompany Templates A and B.

Contractors must complete this table to indicate all the contract requirements that are applicable to their Subcontractors or Downstream Subcontractor, depending on the functions that are delegated to the respective entities.

This table also references obligations of Contractor where delegation must be contractually prohibited. While Contractor must not delegate contractual duties and obligations where delegation is contractually prohibited, Contractor or Subcontractor or Downstream Subcontractor may include related contractual requirements in their Agreements. For example, while Contractor may not delegate the functions of a Compliance Program, they may require Subcontractor and Downstream Subcontractors to maintain their own compliance programs. Regardless of Contractor's system of delegation, Contractor remains obligated to ensure performance of all duties and obligations under the Contract.

Fully Delegated Subcontractors must comply with all contractual requirements. Partially Delegated Subcontractors and Downstream Partially Delegated Subcontractors, and Administrative Subcontractors and Downstream Administrative Subcontractors must at minimum comply with requirements outlined in Exhibit A, Attachment III, Subsection 3.1.5.B *(Subcontractor and Downstream Subcontractor Agreement Requirements)*.

Additional requirements may apply depending on the nature of the function or functions delegated. For example, if a Subcontractor delegates claims processing to an Administrative Downstream Subcontractor for this function, the Administrative Downstream Subcontractor must comply with Exhibit A, Attachment III, Subsection 3.3.5 *(Claims Processing)* for all requirements related to timely processing of claims.

Delegating functions or including contractual provisions in Subcontractor Agreements or Downstream Subcontractor Agreements does not absolve Contractor of ensuring compliance of the Subcontractors or Downstream Subcontractors.

Note:

(1) Must not be delegated: These rows reference contractual requirements associated with functions for which delegation is contractually prohibited. While Contractor must not delegate contractual duties and obligations where delegation is legally or contractually prohibited, Contractor may include related contractual requirements in the

Subcontractor Agreements. For example, while Contractor may not delegate the functions of a Compliance Program, they may require Subcontractor and Downstream Subcontractors to maintain their own compliance programs.

Contractor Name:

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
1.0 Organization	
1.1 Plan Organization and Administration	
1.1.1 Legal Capacity	☐
1.1.2 Key Personnel Disclosure Form	☐
1.1.3 Conflict of Interest – Current and Former State Employees	☐
1.1.4 Contract Performance	☐
1.1.5 Medical Decisions	☐
1.1.6 Medical Director	☐
1.1.7 Chief Health Equity Officer	*(1) Must not be delegated*
1.1.8 Key Personnel Changes	☐
1.1.9 Administrative Duties/Responsibilities	☐
1.1.10 Member Representation	☐
1.1.11 Diversity, Equity, and Inclusion Training	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
1.2 Financial Information	
1.2.1 Financial Viability and Standards Compliance	☐
1.2.2 Contractor's Financial Reporting Obligations	☐
1.2.3 Independent Financial Audit Reports	☐
1.2.4 Cooperation with DHCS' Financial Audits	☐
1.2.5 Medical Loss Ratio	*(1) Must not be delegated*
1.2.6 Contractor's Obligations	☐
1.2.7 Community Reinvestment Plan and Report	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
1.3 Program Integrity and Compliance Program	
1.3.1 Compliance Program	*(1) Must not be delegated*
1.3.2 Fraud Prevention Program	☐
1.3.3 Provider Screening, Enrolling, and Credentialing/Recredentialing	☐
1.3.4 Contractor's Obligations Regarding Suspended, Excluded, and Ineligible Providers	☐
1.3.5 Disclosures	☐
1.3.6 Treatment of Overpayment Recoveries	☐
1.3.7 Federal False Claims Act Compliance and Support	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
2.0 Systems and Processes	
2.1 Management Information System	
2.1.1 Management Information System Capability	☐
2.1.2 Encounter Data Reporting	☐
2.1.3 Participation in the State Drug Rebate Program	☐
2.1.4 Network Provider Data Reporting	☐
2.1.5 Program Data Reporting	☐
2.1.6 Template Data Reporting	☐
2.1.7 Management Information System/Data Audits	☐
2.1.8 Management Information System/Data Correspondence	☐
2.1.9. Tracking and Submitting Alternative Format Selections	☐
2.1.10 Interoperability Application Programming Information System Requirements	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
2.2 Quality Improvement and Health Equity Transformation Program	
2.2.1 Quality Improvement and Health Equity Transformation Program Overview	☐
2.2.2 Governing Board	☐
2.2.3 Quality Improvement and Health Equity Committee	☐
2.2.4 Provider Participation	☐
2.2.5 Subcontractor and Downstream Subcontractor Quality Improvement Activities	☐
2.2.6 Quality Improvement and Health Equity Transformation Program Policies and Procedures	☐
2.2.7 Quality Improvement and Health Equity Annual Plan	☐
2.2.8 National Committee for Quality Assurance Accreditation	*(1) Must not be delegated*
2.2.9 External Quality Review Requirements	☐
2.2.10 Quality Care for Children	☐
2.2.11 Skilled Nursing Facilities—Long-Term Care	☐
2.2.12 Disease Surveillance	☐
2.2.13 Credentialing and Recredentialing	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
2.3 Utilization Management Program	
2.3.1 Prior Authorizations and Review Procedures	☐
2.3.2 Timeframes for Medical Authorization	☐
2.3.3 Review of Utilization Data	☐
2.3.4 Delegating Utilization Management Activities	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
3.0 Provider, Network Providers, Subcontractors, and Downstream Subcontractors	
3.1 Network Provider Agreements, Subcontractor Agreements, Downstream Subcontractor Agreements, and Contractor's Oversight Duties	
3.1.1 Overview of Contractor's Duties and Obligations	☐
3.1.2 DHCS Approval of Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements	☐
3.1.3 Contractor's Duty to Disclose All Delegated Relationships and to Submit Delegation Reporting and Compliance Plan	☐
3.1.4 Contractor's Duty to Ensure Subcontractor, Downstream Subcontractor, and Network Provider Compliance	*(1) Must not be delegated*
3.1.5 Requirements for Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements	☐
3.1.6 Financial Viability of Subcontractors, Downstream Subcontractors, and Network Providers	☐
3.1.7 Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements with Federally Qualified Health Centers and Rural Health Clinics	☐
3.1.8 Network Provider Agreements with Safety-Net Providers	☐
3.1.9 Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements with Local Health Departments	☐
3.1.10 Nondiscrimination in Provider Contracts	☐
3.1.11 Public Records	☐
3.1.12 Requirement to Post	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
3.2 Provider Relations	
3.2.1 Exclusivity	☐
3.2.2 Provider Dispute Resolution Mechanism	☐
3.2.3 Out-of-Network Provider Relations	☐
3.2.4 Contractor's Provider Manual	☐
3.2.5 Network Provider Training	☐
3.2.6 Emergency Department Protocols	☐
3.2.7 Prohibited Punitive Action Against the Provider	☐
3.2.8 Submittal of Inpatient Days Information	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
3.3 Provider Compensation Arrangements	
3.3.1 Compensation and Value Based Arrangements	☐
3.3.2 Capitation Arrangements	☐
3.3.3 Provider Financial Incentive Program Payments	☐
3.3.4 Identification of Responsible Payor	☐
3.3.5 Claims Processing	☐
3.3.6 Prohibited Claims	☐
3.3.7 Federally Qualified Health Center, Rural Health Center, and Indian Health Care Provider	☐
3.3.8 Non-Contracting Certified Nurse Midwife, Nurse Practitioner, and Licensed Midwife Providers	☐
3.3.9 Non-Contracting Family Planning Providers	☐
3.3.10 Sexually Transmitted Disease	☐
3.3.11 Human Immunodeficiency Virus Testing and Counseling	☐
3.3.12 Immunizations	☐
3.3.13 Community Based Adult Services	☐
3.3.14 Organ and Bone Marrow Transplants	☐
3.3.15 Long-Term Care Services	☐
3.3.16 Emergency Services and Post-Stabilization Care Services	☐
3.3.17 Provider-Preventable Conditions	☐
3.3.18 Prohibition Against Payment to Excluded Providers	☐
3.3.19 Compliance with Directed Payment Initiatives and Related Reimbursement Requirements	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
4.0 Member	
4.1 Marketing	
4.1.1 Training and Certification of Marketing Representatives	☐
4.1.2 Marketing Plan	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
4.2 Enrollments and Disenrollments	
4.2.1 Enrollment	☐
4.2.2 Disenrollment	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
4.3 Population Health Management and Coordination of Care	
4.3.1 Population Health Management Program Requirements	☐
4.3.2 Population Needs Assessment	☐
4.3.3 Data Integration and Exchange	☐
4.3.4 Medi-Cal Connect (DHCS' PHM Service) Population Health Management Service	☐
4.3.5 Population Risk Stratification and Segmentation, and Risk Tiering	☐
4.3.6 Screening and Assessments	☐
4.3.7 Care Management Programs	☐
4.3.8 Basic Population Health Management	☐
4.3.9 Other Population Health Requirements for Children	☐
4.3.10 Transitional Care Services	☐
4.3.11 Targeted Case Management Services	☐
4.3.12 Mental Health Services	☐
4.3.13 Alcohol and Substance Use Disorder Treatment Services	☐
4.3.14 California Children's Services	☐
4.3.15 Services for Persons with Developmental Disabilities	☐
4.3.16 School-Based Services	☐
4.3.17 Dental	☐
4.3.18 Direct Observed Therapy for Treatment of Tuberculosis	☐
4.3.19 Women, Infants, and Children Supplemental Nutrition Program	☐
4.3.20 Home and Community-Based Services Programs	☐
4.3.21 In-Home Supportive Services	☐
4.3.22 Indian Health Care Providers	☐
4.3.23 Justice Involved Reentry Coordination	☐

4.3.24 Managed Care Liaisons	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
4.4 Enhanced Care Management	
4.4.1 Contractor's Responsibilities for Administration of Enhanced Care Management	☐
4.4.2 Populations of Focus for Enhanced Care Management	☐
4.4.3 Enhanced Care Management Providers	☐
4.4.4 Enhanced Care Management Provider Capacity	☐
4.4.5 Enhanced Care Management Model of Care	☐
4.4.6 Member Identification for Enhanced Care Management	☐
4.4.7 Authorizing Members for Enhanced Care Management	☐
4.4.8 Assignment to an Enhanced Care Management Provider	☐
4.4.9 Initiating Delivery of Enhanced Care Management	☐
4.4.10 Discontinuation of Enhanced Care Management	☐
4.4.11 Core Service Components of Enhanced Care Management	☐
4.4.12 Data System Requirements and Data Sharing to Support Enhanced Care Management	☐
4.4.13 Oversight of Enhanced Care Management Providers	☐
4.4.14 Payment of Enhanced Care Management Providers	☐
4.4.15 Enhanced Care Management Reporting Requirements	☐
4.4.16 Enhanced Care Management Quality and Performance Incentive Program	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
4.5 Community Supports	
4.5.1 Contractor's Responsibility for Administration of Community Supports	☐
4.5.2 Optional Community Supports	☐
4.5.3 Transitional Rent	☐
4.5.4 Community Supports Providers	☐
4.5.5 Community Supports Provider Capacity	☐
4.5.6 Community Supports Model of Care	☐
4.5.7 Identifying Members for Community Supports	☐
4.5.8 Authorizing Members for Community Supports and Communication of Authorization Status	☐
4.5.9 Referring Members to Community Supports Providers for Community Supports	☐
4.5.10 Data System Requirements and Data Sharing to Support Community Supports	☐
4.5.11 Contractor's Oversight of Community Supports Providers	☐
4.5.12 Delegation of Community Supports Administration to Network Providers, Subcontractors, or Downstream Subcontractors	☐
4.5.13 Payment of Community Supports Providers	☐
4.5.14 Community Supports Reporting Requirements	☐
4.5.15 Community Supports Quality and Performance Incentive Program	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
4.6 Member Grievance and Appeal System	
4.6.1 Grievance and Appeal Program Requirements	☐
4.6.2 Grievance Process	☐
4.6.3 Discrimination Grievances	☐
4.6.4 Notice of Action	☐
4.6.5 Appeal Process	☐
4.6.6 Responsibilities in Expedited Appeals	☐
4.6.7 State Hearings and Independent Medical Reviews	☐
4.6.8 Continuation of Services Until Appeal and State Hearing Rights Are Exhausted	☐
4.6.9 Grievance and Appeal Reporting and Data	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
5.0 Services – Scope and Delivery	
5.1 Member Services	
5.1.1 Members Rights and Responsibilities	☐
5.1.2 Member Services Staff	☐
5.1.3 Member Information	☐
5.1.4 Primary Care Provider Selection	☐
5.1.5 Notices of Action for Denial, Deferral, or Modification of Prior Authorization Requests	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
5.2 Network and Access to Care	
5.2.1 Access to Network Providers and Covered Services	☐
5.2.2 Network Capacity	☐
5.2.3 Network Composition	☐
5.2.4 Network Ratios	☐
5.2.5 Network Adequacy Standards	☐
5.2.6 Access to Emergency Service Providers and Emergency Services	☐
5.2.7 Out-of-Network Access	☐
5.2.8 Specific Requirements for Access to Programs and Covered Services	☐
5.2.9 Network and Access Changes to Covered Services	☐
5.2.10 Access Rights	☐
5.2.11 Cultural and Linguistic Programs and Committees	☐
5.2.12 Continuity of Care for Seniors and Persons with Disabilities	☐
5.2.13 Network Reports	☐
5.2.14 Site Review	☐
5.2.15 Street Medicine	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
5.3 Scope of Services	
5.3.1 Covered Services	☐
5.3.2 Medically Necessary Services	☐
5.3.3 Initial Health Appointment	☐
5.3.4 Services for Members Less Than 21 Years of Age	☐
5.3.5 Services for Adults	☐
5.3.6 Pregnant and Postpartum Members	☐
5.3.7 Services for All Members	☐
5.3.8 Investigational Services	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
5.4 Community Based Adult Services	
5.4.1 Covered Services	☐
5.4.2 Coordination of Care	☐
5.4.3 Required Reports for the Community Based Adult Services Program	☐
5.4.4 Community Participation	☐
5.4.5 Community Based Adult Services Program Integrity	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
5.5 Mental Health and Substance Use Disorder Benefits	
5.5.1 Mental Health Parity Requirements	☐
5.5.2 Non-Specialty Mental Health Services and Substance Use Disorder Services	☐
5.5.3 Non-Specialty Mental Health Services Providers	☐
5.5.4 Emergency Mental Health and Substance Use Disorder Services	☐
5.5.5 Mental Health and Substance Use Disorder Services Disputes	☐
5.5.6 No Wrong Door for Mental Health Services	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
5.6 MOUs with Local Government Agencies, County Programs, and Third Parties	
5.6.1 MOU Purpose	☐
5.6.2 MOU Requirements	☐
5.6.3 MOU Oversight and Compliance	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
6.0 Emergency Preparedness and Response	
6.1.1 General Guidance	☐
6.1.2 Business Continuity Emergency Plan	☐
6.1.3 Member Emergency Preparedness Plan	☐
6.1.4 California's Standardized Emergency Management System	☐
6.1.5 Reporting Requirements During an Emergency	☐
6.1.6 DHCS Emergency Directives	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
7.0 Operations Deliverables and Requirements	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit E	
1.0 Program Terms and Conditions	
1.1.1 Governing Law	☐
1.1.2 DHCS Guidance	☐
1.1.3 Contract Interpretation	☐
1.1.4 Assignments, Mergers, Acquisitions	☐
1.1.5 Independent Contractor	☐
1.1.6 Amendment and Change Order Process	☐
1.1.7 Delegation of Authority	*(1) Must not be delegated*
1.1.8 Authority of the State	☐
1.1.9 Fulfillment of Obligations	☐
1.1.10 Obtaining DHCS Approval	☐
1.1.11 Certifications	☐
1.1.12 Notices	☐
1.1.13 Term	☐
1.1.14 Service Area	☐
1.1.15 Contract Extension	☐
1.1.16 Termination	☐
1.1.17 Phaseout Requirements	☐
1.1.18 Indemnification	☐
1.1.19 Sanctions	☐
1.1.20 Liquidated Damages	☐
1.1.21 Contractor’s Dispute Resolution Requirements	☐
1.1.22 Inspection and Audit of Records and Facilities	☐
1.1.23 Confidentiality of Information	☐
1.1.24 Pilot Projects	☐

1.1.25 Cost Avoidance and Post-Payment Recovery (PPR) of Other Health Coverage (OHC)	☐
1.1.26 Third-Party Tort and Workers' Compensation Liability	☐
1.1.27 Litigation Support	☐
1.1.28 Equal Opportunity Employer	☐
1.1.29 Federal and State Nondiscrimination Requirements	☐
1.1.30 Discrimination Prohibitions	☐
1.1.31 Small Business Participation and Disabled Veteran Business Enterprises (DVBE) Reporting Requirements	☐
1.1.32 Conflict of Interest Avoidance Requirements	*(1) Must not be delegated*
1.1.33 Guaranty Provision	☐
1.1.34 Priority of Provisions	☐
1.1.35 Additional Incorporated Provisions – Proposals	☐
1.1.36 Miscellaneous Provisions	☐
1.1.37 Data Sharing	☐

Exhibit K – Excluded Provisions as to Contractors Not Licensed Pursuant to the Knox-Keene Health Care Service Plan Act of 1975

Unless otherwise specified in this Contract, the following provisions of the Knox-Keene Health Care Service Plan Act of 1975 and its implementing regulations (28 California Code of Regulations (CCR) section 1000, *et seq*.) (KKA) are excluded from this Contract if Contractor is not licensed to operate as a health care service plan pursuant to the KKA. This list is not exhaustive or exclusive since other provisions of the KKA may also be excluded from the Contract pursuant to Exhibit E, Subsection 1.1.1.D (*Applicability of the Knox-Keene Act*) or other provisions of the Contract:

1. Health and Safety Code (H&S) sections 1341 – 1341.14.
2. H&S sections 1342.4 – 1342.73.
3. H&S sections 1346 – 1347.5.
4. H&S sections 1348.9 – 1348.96.
5. H&S, Article 3 of Chapter 2.2 of Division 2.
6. H&S, Article 3.1 of Chapter 2.2 of Division 2.
7. H&S, Article 3.15 of Chapter 2.2 of Division 2.
8. H&S, Article 3.16 of Chapter 2.2 of Division 2.
9. H&S, Article 3.17 of Chapter 2.2 of Division 2.
10. H&S, Article 3.5 of Chapter 2.2 of Division 2.
11. H&S sections 1359 – 1361.1.
12. H&S section 1363.01.
13. H&S section 1363.03.
14. H&S section 1363.05.
15. H&S, Article 4.5 of Chapter 2.2 of Division 2.
16. H&S sections 1367.002 – 1367.009.
17. H&S section 1367.010 – 1367.012.
18. H&S section 1367.02.
19. H&S section 1367.035.
20. H&S section 1367.042.
21. H&S section 1367.07 – 1367.1
22. H&S sections 1367.45 – 1367.46.
23. H&S section 1367.15.
24. H&S section 1367.23.
25. H&S section 1367.30.
26. H&S section 1368.2
27. H&S sections 1368.04 – 1368.05.
28. H&S section 1372.
29. H&S section 1373.5.
30. H&S sections 1373.621 – 1373.622.
31. H&S section 1373.7 – 1373.8.
32. H&S section 1373.95.
33. H&S section 1373.10.
34. H&S section 1373.14.
35. H&S section 1373.18.

36. H&S section 1374.
37. H&S sections 1374.5 – 1374.58.
38. H&S sections 1374.9 – 1374.10.
39. H&S, Article 5.5 of Chapter 2.2 of Division 2.
40. H&S, Article 5.55 of Chapter 2.2 of Division 2.
41. H&S sections 1374.65 – 1374.721.
42. H&S sections 1374.723 – 1374.76.
43. H&S sections 1375.1 – 1375.3.
44. H&S section 1376.
45. H&S section 1377.
46. H&S sections 1379.5 – 1380.
47. H&S section 1381.
48. H&S section 1383.
49. H&S section 1385.
50. H&S, Article 6.1 of Chapter 2.2 of Division 2.
51. H&S, Article 6.2 of Chapter 2.2 of Division 2.
52. H&S, Article 7 of Chapter 2.2 of Division 2.
53. H&S sections 1389.1 – 1389.7.
54. H&S, Article 8 of Chapter 2.2 of Division 2.
55. H&S, Article 8.5 of Chapter 2.2 of Division 2.
56. H&S sections 1395.6.H&S sections 1399.5.
57. H&S section 1399.57.
58. H&S, Article 10 of Chapter 2.2 of Division 2.
59. H&S, Article 10.2 of Chapter 2.2 of Division 2.
60. H&S, Article 11 of Chapter 2.2 of Division 2.
61. H&S, Article 11.1 of Chapter 2.2 of Division 2.
62. H&S, Article 11.5 of Chapter 2.2 of Division 2.
63. H&S, Article 11.8 of Chapter 2.2 of Division 2.

Exhibit L – Requirements Specific to Contractor

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